DOCUMENT RESUME

ED 357 525 EC 302 067

AUTHOR	Henderson, Elissa, Ed.; Algarin, Alissa, Ed.
TITLE	Update: Improving Services for Emotionally Disturbed Children. Volumes 4-7, Winter 1988-Summer 1991.
INSTITUTION	University of South Florida, Tampa. Research and Training Center for Children's Mental Health.
PUB DATE	91
NOTE	82p.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Update: Improving Services for Emotionally Disturbed Children; v4-7 Win 1988-Sum 1991
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Adolescents; Agency Cooperation; Children; Child Welfare; *Emotional Disturbances; Evaluation Methods; Family Programs; Individualized Programs; *Intervention; *Mental Health Programs; Placement; Program Development; Residential Programs; Social Services; Therapy
IDENTIFIERS	Child and Adolescent Service System Program; Family Needs

ABSTRACT

This compilation of four annual newsletter issues on services for children with emotional disturbances presents reports of activities, meetings, services, and programs around the country as well as various feature articles. Activities funded under the Child and Adolescent Service System Program are highlighted. In the Winter 1988-89 issue, an article on alternatives to residential placements describes states' efforts to develop new services, modify fiscal incentives, establish stricter gatekeeping mechanisms, increase accountability, develop policies and statutes, and modify attitudes. In the Summer 1989 issue, an article by Jane Knitzer and Susan Yelton discusses interagency collaboration among public child welfare agencies and child mental health agencies, emphasizing the growth of family preservation services and appropriate placement. The Summer 1990 issue features an article by Michael K. Johnson and Robert M. Friedman which summarizes issues and trends in the development of effective treatment plans. The feature article of the Summer 1991 issue is titled "Strength-Based Assessment" written by Michael K. Johnson and Robert M. Friedman. It discusses the assessment and utilization of individual and family strengths in treatment planning and offers guidelines for staff to implement strength-based assessments. Feature articles include references. (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED357525

Update: Improving Services for Emotionally Disturbed Children

Volumes 4-7
Number 1
Winter 1988-Summer 1991

Update
Research and Training Center for Children's Mental Health
13301 Bruce B. Downs Boulevard
Tampa, Florida 33612-3899

PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Robert M Friedman
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Florida Mental Health Institute. University of South Florida. Tampa. Florida

UPDATE

Improving Services for Emotionally Disturbed Children

VOLUME 4, NUMBER 1 WINTER 1988-89

NMHA Presents Invisible Children Report

A new study on children with serious emotional problems, conducted by the National Mental Health Association (NMHA), has found that "state agencies often did not know the exact number of children they placed in out-of-state and in-state residential treatment facilites, the amount of money being spent on their treatment, their diagnoses, and even their whereabouts."

The results of the study were presented at the annual meeting of NMHA in Hartford, Connecticut, November 18, 1988 by Chris Zeigler-Dendy of Atlanta, GA, and Ann Ince of Knoxville, TN. The information for the report was gathered through a survey of state officials.

The particular focus of the report was on children served in out-of-state residential treatment facilities, state mental hospitals, and in-state residential treatment facilities. The project was called the "Invisible Children Project" by NMHA which used the term as "a euphemism for children and adolescents with serious emotional problems who are not receiving proper treatment."

Preston Garrison, NMHA Executive Director and Chris Zeigler-Dendy at the presentation of the Invisible Children Report in Hartford, CT.

Data from 37 states showed that 4,926 children and adolescents were placed in out-of-state residential treatment facilities in a one-year time period. An additional 22,578 children and adolescents were placed in state hospitals in the 50 states in a one-year period.

The average length of stay in treatment was found to be slightly over one year for out-of-state placements, just under one year for in-state residential placements, and approximately four months for state hospitals.

The use of out-of-state placements was found to vary from states that had no out-of-state placements to 847 such placements. The placements were made by a variety of agencies, including child welfare, juvenile justice, education, and mental health.

While the report indicates that treatment in these types of facilities is sometimes needed, concern is expressed that "many Invisible Children could have been

Continued on Page 16.

Parents Plan National Agenda For Children

A group of 24 professionals and 26 parents of children who are experiencing emotional problems met in Arlington, VA, Dec. 10-11, 1988 to discuss a national agenda for the families and their children. After two days of sometimes intense discussion, the group decided that a national organization with a single focus on children who are experiencing emotional problems and their families was needed. This organization would work with already existing groups, and would be parent-driven.

The meeting was sponsored by the Research and Training Center at Portland State University with planning assistance from the National Institute of Disability and Rehabilitation Research, the National Institute of Mental Health, the National Alliance for the Mentally Ill, and the National Mental Health Association.

Representatives from advocacy groups representing local, state, and national organizations spoke to the group and shared experiences. Federal officials also addressed the group and spoke of the value of a single voice in advocacy efforts.

The conference focused on four major issues: Family Support Services; Access to Education; Relinquishing Parental Custody to Obtain Services; and Coordination of Services at the Individual Level. A professional and a parent presented an issue paper on each of the topics and then the group divided into four sub-groups to develop a set of goal statements and an action plan for each issue.

The group was charged to not adjourn the meeting until some mechanism was established to continue the momentum that had been established. After much discussion about the pros and cons of

Continued on Page 16.

NEWS UPDATES

Mental Health Forum	3
OSERS Report	4
Report on MH Care	5
Training Institutes	6
ADM Block Grant	7

DEPARTMENT UPDATES

Director's Column	2
Program Update	8
CASSP	11
Cross Country	12
Research	14
Resources	15

RESEARCH AND TRAINING
CENTER FOR CHILDREN'S
MENTAL HEALTH

UNIVERSITY OF SOUTH FLORIDA
FLORIDA MENTAL HEALTH INSTITUTE
13301 Bruce B. Downs Boulevard
Tampa, Florida 33612-3899
(813) 974-4500

ADVISORY BOARD MEMBERS

CHRISTINA K. YOUNG, CHAIRPERSON
Stowe, Ohio
COLLEEN L. BEVIS
Tampa, Florida
ADLAI BOYD, PH.D.
University of South Florida
Tampa, Florida
ROBERT E. BRABHAM, PH.D.
National Rehabilitative Association
Alexandria, Virginia
WILLIAM BUZOGANY, M.D.
Mendota Mental Health Institute
Madison, Wisconsin
KARL W. DENNIS
Kaleidoscope
Chicago, Illinois
ELINOR ELFNER, PH.D.
Bureau of Education for Exceptional Students
Tallahassee, Florida
DAVID FANSHEL, D.S.W.
Columbia University School of Social Work
New York, New York
JEWELLE TAYLOR GIBBS, PH.D.
University of California
Berkeley, California
MARIO HERNANDEZ, PH.D.
Phoenix School
Camarillo, California
MAREASA ISAACS, PH.D.
Commission of Mental Health Services
Washington, D.C.
RON LANEVE, ED.D.
Rockville, Maryland
BRENDA LYLES, PH.D.
Quality Assurance Monitoring Group
New Orleans, Louisiana
LORELLA A. MCKINNEY, PH.D.
Columbus, Ohio
JO M. PINE, M.S.W.
Mental Health Association
Baton Rouge, Louisiana
HERBERT C. QUAY, PH.D.
University of Miami
Coral Gables, Florida
BARBARA STARFIELD, M.D., M.P.H.
The Johns Hopkins University
Baltimore, Maryland
MURIEL THOMPSON
Wilson, North Carolina
LUDIE WHITE, M.S.
Durham, North C
CHRIS A. ZEIGLE... NDY
Mental Health Asso... on
Decatur, Georgia

U.S.F. ADVISORS
RICHARD DEMBO, PH.D.
WILLIAM FMENER, PH.D.
RAYMOND HILL, ED.D.
LEE HUSTING, PH.D.
AUGUST MAUSER, ED.D.
CALVIN PINKARD, PH.D.
ARCHIE SILVER, M.D.

CONSULTANTS
LENORE BEHAR, Ph.D.
North Carolina Department of Human Resources
Raleigh, North Carolina
TONY BROSKOWSKI, Ph.D.
Preferred Health Care, Inc.
Miami, Florida
LARRY DIAMOND, Ph.D.
SENIOR SHARE
Cambridge, Massachusetts
JANE KNITZER, Ed.D.
Bank Street College of Education
New York, New York
JUDITH TOLMACH, A.C.S.W.
Washington, D.C.
KAREN UNGER, Ph.D.
Boston University
Boston, Massachusetts

CENTER STAFF
ROBERT M. FRIEDMAN, Ph.D.
Executive Director
ALBERT DUCHNOWSKI, Ph.D.
Director, Training, Consultation, & Dissemination
STARR SILVER, Ph.D.
Director, Research
KRISTA KUTASH, M.B.A.
Administrative Director
ELISSA HENDERSON, M.U.A.
UPDATE Editor
KELLY ENZOR-KISE
Production Manager

CENTER PROJECT FOR CHILD WELFARE-
CHILD MENTAL HEALTH COLLABORATION
SUSAN YELTON, M.S.W.
Director

DIRECTOR'S UPDATE

There are several recent developments that have great promise for improving services for children and their families that I would like to comment on in this column.

-- The new children's mental health initiative of the Robert Wood Johnson Foundation is bold, exciting, and well-conceived, and I would like to congratulate the Foundation on this effort. This initiative provides the best opportunity that the children's mental health field has ever had to demonstrate the power and effectiveness of comprehensive community-based systems of care.

-- The "Invisible Children's Project" of the National Mental Health Association represents a monumental effort, and provides the field an important service by calling attention to the continued over-reliance on out-of-state and state hospital placements in many areas. Despite the progress in the development of innovative approaches to reducing the inappropriate use of such placements, as we highlight in our Program Update section of this issue, it is obvious that we still have a long way to go in our endeavors to see family and community-based systems implemented.

-- The efforts of parents of children with serious emotional disorders to agree on a common agenda and to strengthen the mechanisms for getting action on that agenda are exciting to see, and of great importance if substantial progress is to be made.

-- The new research program of the National Institute of Mental Health specifically on "Mental Health Services for Children and Adolescents" is another encouraging sign. There is a major need to enhance the empirical base for our system-building efforts and although the new NIMH program is limited in size, it is significant in recognizing the need for a specialized service system research program for children and adolescents.

-- While speaking of research, we have seen a sizeable increase in the number of papers submitted for presentation at our research conference this year compared to last year. This increased interest bodes well for efforts to strengthen services. The conference will be in Tampa, Feb. 27 - March 1, 1989 (see page 6).

-- The efforts of national mental health organizations to meet together and form a coalition to promote improved mental health services for all groups is also very exciting and promising. Such coalition efforts have been an important missing piece in the past, and are a critical complement to the activities of individual organizations in their efforts to improve mental health services.

We were greatly saddened to learn of the death of Dr. John Butler, 45, on November 25, 1988, from cancer of the pancreas, and would like to express our deepest sympathies to John's wife Pat, and his son Andrew, 9, and his daughter, Louisa, 5. John has been a leader in efforts to improve services for children with handicaps for many years, and among his accomplishments were his leadership role with the Congressional Select Panel for the Promotion of Child Health, and the Collaboration Study of Children with Special Needs of the Robert Wood Johnson Foundation.

I had a chance to meet John in mid-1987 as he focused his efforts in the children's mental health area on behalf of the Robert Wood Johnson Foundation. The exciting new initiative of that Foundation is partially a reflection of his work on their behalf. John was an individual of exceptional wisdom, vision, dedication, humility, and terrific optimism, and we will remember him for these wonderful qualities as we appreciate his enormous contributions on behalf of children.

In tribute to John, the John A. Butler Memorial Fund has been established at the Boston Foundation, 60 State St., Boston, MA 02109, to pursue, in his wife's words, "activities that reflect the values John brought to his roles as children's policy researcher, educator, and father."

National Mental Health Leaders Establish Forum

An effort to establish a national mental health agenda with broad-based organizational support was initiated in Hartford, Connecticut, on November 15-16, 1988. With funding support from the National Institute of Mental Health (NIMH), the National Mental Health Association (NMHA) convened a meeting of Presidents and Executive Directors of national mental health organizations to begin this effort (see list of organizations present in box).

The meeting opened with a presentation by Dr. Lewis Judd, Director of NIMH, who emphasized that the mentally ill "have been distinctly underserved and disadvantaged" in relation to other health problems. He proposed as an all encompassing goal the development of a major campaign to rectify this situation.

Such a campaign, according to Judd, needs to raise national consciousness about the prevalence and seriousness of mental disorders, demonstrate that citizens with mental illness and their families are underserved, and demonstrate that the research field is ready and able to make substantial progress.

Presentations were made to the group on the politics of mental health, research policy, child and adolescent issues, public sector issues, and developments in the private sector.

Dr. Bob Friedman of the Research and Training Center for Children's Mental Health presented on child and adolescent issues. He emphasized the important contributions made by the Child and Adolescent Service System Program of NIMH, and the need to continue this program.

Friedman also addressed the issues of financing, particularly through Medicaid, the need for more research, concerns about the adequacy of school programs for children with serious emotional problems, and the need for interagency efforts on a federal level as well as at a state and community level.

NATIONAL MENTAL HEALTH LEADERSHIP FORUM

American College of Neuropsychopharmacology
American Mental Health Fund
American Psychiatric Association
American Psychological Association
National Alliance for Research on Schizophrenia & Depression
National Alliance for the Mentally Ill
National Association of Private Psychiatric Hospitals
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council of Community Mental Health Centers
National Depressives and Manic Depressives Association
National Institute of Mental Health
National Mental Health Association
National Mental Health Consumers Association

"Participants exhibited a strong desire to meet regularly to help create a strong mental health agenda for the nation," said Preston Garrison, executive director of NMHA. He noted that there is a growing desire to elevate national consciousness concomitant with the level of mental illness in our nation.

The group plans to meet in early February, 1989. For more information contact Leroy Goldman, Acting Director, Office of Policy Analysis and Coordination, NIMH, 5600 Fishers Lane, Rockville, MD 20857.

State Child MH Representatives Identify Priority Issues

Interagency collaboration, financing of services, and development of a children's mental health data base, were identified as top priority issues in a recent survey of state directors of children's mental health services.

The survey was conducted by the State Mental Health Representatives for Children and Youth (SMHRCY), and results were presented at the organization's meeting in Lake Lanier, GA, Nov. 17-18, 1988. According to Paul Vander Velde, Chairperson of the organization, "this was an excellent meeting where people came together to develop issue papers, based upon the results of the survey, that will be used to assist creating the SMHRCY agenda for 1989."

TOP PRIORITY ISSUES FOR CHILDREN'S MENTAL HEALTH

1. Develop better multi-system programs between mental health and child welfare.
2. Develop new sources of funding child mental health services.
3. Improve collaboration with special education.
4. Develop better guidelines for use of existing funding sources for child mental health services.
5. Assess effectiveness of home-based treatment.
6. Develop better guidelines for adequate child mental health management information systems.
7. Improve collaboration with the juvenile justice system (tied for sixth place).
8. Expand the range of child mental health services.
9. Provide earlier identification of children with mental health problems.
10. Develop new treatment models for youth who are emotionally disturbed and delinquent.

Out of 44 separate scoreable items on the survey, the highest ranked priority was "develop better multi-system programs between mental health and child welfare." The interagency area received consistently high ratings. The third highest rated area was collaboration with special education and the sixth highest item was collaboration with the juvenile justice system.

The second highest rated item was "develop new sources of funding child mental health services." The interest in the financing area was also reflected on the item "develop better guidelines for use of existing funding sources for child mental health services" which received the fourth highest ranking.

Based on these ratings, SMHRCY developed position papers which were presented at the State Mental Health Commissioners meeting Dec. 10-13 in Washington, DC to help develop the 1989 SMHRCY agenda.

More information is available from Roy Praschil, National Association of State Mental Health Program Directors, 1101 King St., Suite 160, Alexandria, VA 22314.

OSERS Report:

Enrollment Shows Slight Increase

"The Tenth Annual Report to Congress on the Implementation of the Education of the Handicapped Act" summarizes a decade of federal assistance in special education. The Forward to the report by Madeleine Will, Assistant Secretary, of the U.S. Department of Education, notes that "as a nation we have made substantial progress toward our goal of providing an appropriate education for all children with handicaps."

During the '86-'87 school year 4,421,601 children with handicaps were served. This represents an increase of 1.2% over the number served in '85-'86.

served in '86-'87 increased compared with '85-'86 for children who are SED. In '86-'87, 384,680 children were served, representing a gain of 7,737 which is more than double the previous yearly gain. The variability between states in the percentage of children served as SED continues to be large, ranging from 0.03% to 1.76%.

The Tenth Annual Report presents data on program completion and on where services are delivered in terms of restrictiveness. As in the last report, children who have emotional problems continue to have the poorest outcome in terms of successful program completion. In addition,

Table One

Number/Percent of Children Served by Handicapping Conditions

	All Conditions	Learning Disabled	Mentally Retarded	Emotionally Disturbed
'86 - '87	4,421,601 6.47%*	1,926,097 2.83%*	664,424 0.95%*	384,680 0.57%*
'85 - '86	4,370,244 10.97%	1,872,339 4.73%	686,077 1.68%	376,943 0.95%
Change '85-'86 to '86-'87	+ 51,357	+ 53,758	-21,653	+ 7,737

* Based on estimated resident population (age 3-21) counts. U.S. Bureau of the Census.

However comparisons to the percentages of children served in previous years is difficult since the Office of Special Education and Rehabilitative Services (OSERS), used a different figure in calculating these percents. Previously, the number of children enrolled was used as the divisor, whereas in the Tenth Annual Report the estimated total population of 3-21 year olds is used. Consequently, while the absolute numbers of children has increased, the "percent served" figure is lower than last year (see table one).)

The absolute number of children they are served in the most restrictive settings compared to the other major exceptionalities (see table two).

OSERS is studying alternative methods by which states can provide more accurate data on related educational services. Concerns about the quality of these data, as presently collected, have been raised. For example, states use different definitions of what constitutes a related service and what should be reported.

The report may be ordered from OSERS, Switzer Building, 330 C Street SW, Washington, DC 20202.

Table Two

Exiting/Placement Comparisons

	Diploma or Certificate	Drop-Out	Regular School Bldg.	Homebound/ Hospital
All Conditions	60%	26%	91%	0.74%
SED	42%	41%	79%	2.33%
LD	63%	26%	98%	0.09%
MR	62%	24%	84%	0.41%

CASSP Minority Initiative Produces Draft Monograph

At its October 10 meeting in St. Petersburg, the CASSP Program's Minority Initiative Resource Committee reviewed the draft monograph on "a culturally-competent system of care." The monograph is intended to serve as a resource for developing effective services for minority children who are severely emotionally disturbed.

The draft was developed by a subcommittee that included Terry Cross of Portland, Oregon, Dr. Barbara Bazron of Pittsburgh, Karl Dennis of Chicago, and Dr. Mareasa Isaacs of Washington, DC.

At an afternoon session of CASSP Project Directors, Marva Benjamin, Minority Initiative Director for the CASSP Technical Assistance Center, monitored a panel presentation by the subcommittee on the monograph.

Cross, subcommittee chairman, gave an overview of the committee's approach in developing the report. "Cultural competency," he noted, "is defined as a congruent set of attittudes, policies and practices that come together at every level of service to make sure that the cultural needs of the child are considered in the process of helping."

Cross indicated that culturally competent systems of care are ones that acknowledge the importance of cultural differences, conduct self assessment of cross cultural relations, understand the dynamics that result from cultural differences, share cultural knowledge and provide adaptation of services to cultural needs.

While the monograph talks about working with people who have a cultural orientation different from the system of the provider, the subcomittee's efforts focused on going beyond cultural differences and stressing the development of skills needed to understand the concept of cultural competence. Recommendations on policy development, training, research and resources will also be included in the final report.

For information contact Marva Benjamin, CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Rd, NW, Washington, DC 20007 (202) 364-4164.

Advocates Call For Action On New Medicaid Rule

Even though recently enacted federal law now clarifies the availability of Medicaid (Title XIX of the Social Security Act) funding for educationally-related services to low-income, handicapped children, infants and toddlers, states need to be more aggressive in pursuing Medicaid reimbursement for such services, according to child advocates.

PL100-360, the Medicaid Catastrophic Prevention Act of 1988, signed into law on July 1, assures federal Medicaid matching funds are available to reimburse services related to education even when those services are required under a handicapped student's individualized education program or a disabled infant/toddler's individualized family service plan. Schools and residential facilities may now use Medicaid funds for "related services" such as transportation, corrective developmental, and supportive services including psychological and counseling services. (See Update, Summer 1988.)

But many states are unaware of the amended language or are unsure of the Health Care Financing Administration's (HCFA) guidelines for Medicaid reimbursement, confirms a report by the National Association of State Directors of Special Education. To date, HCFA has not issued definitions pertaining to the new amendment and it may be months before HCFA proposes new regulations.

"HCFA has taken limited action to develop definitions and regulations under the new amendments,' notes Joe Manes of the Mental Health Law Project and coordinator of an 18-member coalition that supported passage of the technical amendment.

In general, "related services" must be included as optional services in most state Medicaid plans, which further limits HCFA reimbursement. Few states offer these optional categories and other technical concerns face local providers and state agencies.

In acknowledging the delay HCFA officials point out that two existing Medicaid mechanisms already can be used for provision of health services to the emotionally handicapped: the use of the Early Periodic Screening, Diagnosis and Treatment Program to provide expanded treatment services, and the use of "targeted" case management as a covered service.

"These examples restrict states to a conservative reimbursement approach," said Allan Bergman, an official with the United Cerebral Palsy Association. "In either case, states need to be aggressive in amending their Medicaid policies and securing state matching funds. Clearly HCFA places the burden upon states to seek reimbursement."

He urges advocates, professionals and providers to work with their state agencies to define and encourage needed changes and expanded coverage in their Medicaid laws.

For more information on how states can increase funding strategies, request a copy of "Medicaid Can Now Pay For Educationally Related Services" in *Word From Washington*, June-July, 1988, United Cerebral Palsy Association, 66 East 34th St., NY, NY 10016.

Report Evaluates States on Treatment of Serious Mental Illness

Asserting that "the lack of adequate services for the seriously mentally ill is the major failure of American medicine and social services," the Public Citizen Health Research Group and the National Alliance for the Mentally Ill released their second report on the status of state mental health programs for the seriously mentally ill.

The nation, as a whole, was cited for failure to provide adequate care for the seriously mentally ill. "Few states place priority on providing quality mental health services," noted one of the authors, Dr. E. Fuller Torrey.

The 1988 survey broadens the scope of the 1986 study comparing state mental health programs. The 1988 survey added two indices, rehabilitation and housing, to the earlier focus on hospital care and outpatient services. It continues its primary focus on the nation's 2 million adults with major mental illness.

A variety of collection methods were used including surveys, questionnaires and field visits to state mental hospitals, community mental health centers and mental health facilities across the nation. Interviews with families, consumers and officials, as well as reviews of federal reports and accrediting agencies were also performed in this study which attempts to address the question, "If I had a family member with a serious mental illness, in what state would the person be most likely to receive good services?"

Dr. E. Fuller Torrey of the Public Health Research Group and co-author of their Report on Mental Health Care.

The report was authored by Dr. Sidney Wolfe and Dr. Torrey of the Public Health Research Group, and Laurie M. Flynn, Executive Director of the National Alliance for the Mentally Ill.

The report states that care for the seriously mentally ill in state mental hospitals is worse than two years ago while outpatient services were moderately better. Rehabilitation and housing remain the most serious problems of the current system.

"The intent of this report," noted Dr. Torrey, "is to bring about needed changes on a major social issue." A third report is scheduled in 1990, and will enlist the help of the State Mental Health Program Directors.

Some controversy has arisen in response to this report. According to Charles G. Ray, Executive Director of The National Council of Community Mental Health Centers (NCCMHC), the report is well meant but flawed by "rhetorically excessive tone" and questionable data sources. Ray maintains that the report may "serve to divide consumers, families and providers -- people who should be working together to assure the availability and accessiblity of quality mental health services."

The report, *Care of the Seriously Mentally Ill: A Rating of State Programs* is available from: Health Research Group, Dept. CSMI, 2000 P St., NW, Washington, DC. $10 per copy. The comments of Charles G. Ray are available from Jim Finley, Director, Government Relations, NCCMHC, 12300 Twinbrook Pkwy., #320, Rockville, MD 20852.

Session Urges Parent Involvement

A special session at the CASSP Training Institutes held in Boulder, Colorado in July was devoted to the involvement of parents in all aspects of service delivery to children and adolescents who are severely emotionally disturbed.

Judith Katz-Leavy, Program Director of CASSP at the National Institute of Mental Health, promoted the concept of "families as allies" in the system of care, emphasizing the critical need to ensure that parents are full participants in the planning and delivery of services at national, state, and local levels. Katz-Leavy noted that parents' involvement with their child is usually life-long and that the parent is frequently the one consistent care manager that the child can count on. Thus, service systems should support parents and include their perspective in planning.

She also acknowledged that parents of children with emotional disturbances have needs of their own including the need for relief through respite care and for sharing experiences with other parents.

Katz-Leavy stressed that while there are dysfunctional, abusive, and neglectful families which may cause serious emotional damage to their children, "there literally are thousands of familes in this country composed of perfectly competent parents who still have a child with severe emotional problems, families who love that child and would do anything to help restore the child's mental health. And even in those families where dysfunction does exist, there are strengths, and we need to work with those families as well to build on those strengths."

Judith Sturtevant, the parent of an 11 year-old son with severe emotional problems and the Parent Representative on the State of Vermont Interagency Team, specifically addressed ways in which service systems can become more responsive to the needs of parents and families. Among the strategies she discussed were:

- Provide services at times when working parents and parents with other children can more readily take advantage of them.
- Solicit parents to serve on boards, planning committees, etc. to help design and oversee programs.
- Provide specialized day care and a resource list of individuals qualified to provide respite care.
- Listen to parents as partners, not as clients.
- Share information about the child in terms that parents can understand.
- Attune yourself to the family's strengths, resources and unique coping styles, and treat each family individually.
- Assist parents in locating or organizing parent support groups.
- Keep in mind that as with other mental and physical illnesses, children and adolescents with severe emotional disturbances and their families go through up and down periods.
- Hold IEP meetings on neutral territory after school hours, and encourage parents to bring an advocate and/or tape recorder to these meetings.

Judith Sturtevant, parent-presenter at a special session of the CASSP Training Institutes held in Boulder, CO.

**Note:* *This article was prepared for UPDATE by Beth Stroul. More information on the special session can be obtained from the CASSP TA Center.*

RESEARCH CONFERENCE

The Research and Training Center for Children's Mental Health, Florida Mental Health Institute, is pleased to announce the Second Annual Research Conference "Children's Mental Health Services and Policy: Building a Research Base" at the Harbour Island Hotel in Tampa, February 27 through March 1, 1989.

Presentations will be made by national leaders on topics such as service system effectiveness, service need assessment, prevalence of emotional disturbance, and approaches to measurement and design.

The registration fee is $150 per person. Conference information, brochure and registration forms are available from Kelly Enzor-Kise at the Research Center, Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL 33612 or call (813) 974-4500.

MAKE YOUR RESERVATIONS NOW!

Strong Response to RWJ Program

Nearly all 50 states, the District of Columbia and Puerto Rico submitted letters of intent to the Robert Wood Johnson Foundation under their new grant program, "Mental Health Services Program for Youth." This new initiative seeks to improve mental health services for seriously mentally ill children and youth through the encouragement of multi-agency, state-community partnerships (see Update, Summer 1988).

"The response is tremendous," said Dr. Robert Cole, Deputy Director of the program, "and there is a lot of enthusiasm for the program." Over a five-year period the program will generate $20.4 million in awards.

At the state level, the RWJ grants will foster coordination among state agencies and promote expansion of funding strategies. At the community level, the grants will promote interagency coordination of related services for children among education, juvenile justice, child welfare and mental health agencies.

Under the program, 12 one-year development grants of up to $100,000 will be awarded. Of these sites, eight grantees will then be eligible for 2 two-year implementation grants of up to $2.4 million each. These grants will make it possible to expand existing services in a given community by $1 million when matching funds are included. Application deadline is February 6, 1989. Grant awards will be announced August 1, with project start-ups to begin in the fall of 1989.

More information on this program can be obtained from Dr. Mary Jane England, Prudential Insurance Company, 56 N. Livingston Ave., Roseland, NJ 07068 (201) 716-6882.

New Reports on Children's MH

The initiation of three separate reports in the child and adolescent mental health field was announced recently.

The U.S. Office of Technology Assessment (OTA), as part of an overall examination of adolescent health issues, will do a paper specifically on adolescent mental health, according to Kirsten Rowe, an OTA analyst in the Health Program Office. OTA addresses topics at the request of Congress.

In December, 1986, OTA issued a background paper on "Children's Mental Health: Problems and Services." According to Rowe, the new paper "will focus on young people 10-19," while the earlier paper was broader in focus.

Rowe indicated that a panel of advisors to the OTA study on adolescent health emphasized the importance of both the mental health and substance abuse areas. As a result, separate papers will be prepared on each of these topics.

The National Governors' Association (NGA) has commissioned a study that will examine the status of children's mental health services. This study is expected to take a broad perspective and to address major issues such as barriers to effective delivery of services and financing of services.

The report is an outgrowth of an earlier report on services for chronically mentally ill adults. It will be done under the auspices of the Human Resources Committee, chaired by Governor Celeste of Ohio. Dr. Steve Hill of Tallahassee, Florida will serve as a consultant to the Committee. The report is expected to be completed by spring, 1989, in time for the NGA to adopt a policy statement on children's mental health at its summer, 1989 meeting.

At the same time, the Institute of Medicine of the National Academy of Sciences is conducting a study for the National Institute of Mental Health that specifically focuses on the research needs in the children's mental health area. This study includes task forces specifically looking at research needs on "Causes and Determinants of Childhood Mental Disorders," "Treatment Research," "Assessment, Classification and Epidemiology: Scope and Magnitude of the Problem," and "Manpower and Institutional Supports for Research."

This report should be completed by the summer, 1989. The Chair of the Steering Committee is Dr. James Leckman of Yale University, and the Vice-Chair is Dr. Glen Elliott of Stanford University.

Additional information on the studies can be obtained from the following individuals: OTA, Ms. Kirsten Rowe, Health Program Office, OTA, US Congress, Washington, DC 20510; National Governors' Association, Ms. Alicia Smith, 444 N. Capitol Street #250, Washington, DC 20001; and Institute of Medicine, Frederic Solomon, MD, 2101 Constitution Ave., NW, Washington, DC 20418.

NIMH Issues Call For Services Research

The National Institute of Mental Health (NIMH) has issued an announcement calling for research proposals specifically on "Mental Health Services for Children and Adolescents." The announcement was issued in December, 1988, and the first due date for proposals will be April 1, 1989.

According to Dr. Kelly Kelleher of the Division of Biometry and Applied Sciences, which issued the announcement, the new research program is part of a larger NIMH plan to improve research on service systems, and is consistent with NIMH's effort to improve research both on child and adolescent mental disorders and on service system issues.

The scope of the research that can be covered under this announcement is broad, including topics such as the organization and delivery of care, coordination of mental health services across agencies, research on services to special populations, and financing issues.

The total amount of funding for the research program is not definite yet, according to Kelleher. The next deadline period for submissions after April 1, 1989 will be June 1, 1989.

Information can be obtained from Kelly Kelleher, Division of Biometry and Applied Sciences, NIMH, 5600 Fishers Lane, Rockville, MD 20857.

Congress Approves 10% Set-Aside For Children

Immediately before adjourning, Congress passed the Omnibus Anti-Drug Abuse Bill, which provided increased authorizations for the Alcohol, Drug Abuse and Mental Health Block Grant. It included a 10% set-aside for children's mental health services, as well as set-asides for new services, data collection and alcohol treatment services for women. The bill also revised the allocation formula used to distribute block grant funds to the states.

As a condition of the community mental health block grant, the children's set-aside specifically states that:

"10% of funds must go to support services for seriously emotionally disturbed children and adolescents beginning October 1, 1988. By the end of fiscal year 1990, 55% of the 10% must support new or expanded services that were not in existence as of October 1, 1988."

For FY 1989, $805.6 million is appropriated for the expanded Alcohol, Drug Abuse and Mental Health Block Grant, of which $204 million is designated for mental health services. Although funds for the ADM block grant were increased, mental health will receive a far smaller portion of the total as compared with the previous ADM Block Grants, notes the National Mental Health Association.

After weeks of negotiation, Congress approved the Omnibus Drug Bill which includes provisions from earlier versions of House and Senate approved bills, and incorporated several other freestanding bills. The bill signed by President Reagan as PL 100-690, provides for stronger drug enforcement efforts and expands drug abuse education, prevention and treatment programs.

Reaction to the various set-asides contained in the approved bill, such as the one for children's mental health services, is mixed. On one hand advocates are pleased that increased focus is placed upon children's services. Brian Wilcox, Ph.D., Director of Public Interest Legislation, American Psychological Association noted that "this set-aside provides a symbolic purpose rather than just financial support. Through this legislation, the federal government can point out to the states the serious plight of underfunding for children's services."

On the other hand, state officials are concerned that the set-aside will backlash as other interest groups demand similar treatment. "We have always been opposed to any type of set asides and feel they provide a dangerous precedent," said Harry Schnibbe, Executive Director of the National Association of State Mental Health Program Directors.

PROGRAM UPDATE

Alternatives to Residential Placements

Within a system of care, there is a need for each type of service from the least restrictive to the most restrictive and from the least intensive to the most intensive. However, one of the guiding principles for a system of care is that children with emotional problems "should receive services within the least restrictive, most normative environment that is clinically appropriate" (Stroul & Friedman, 1986).

The report of the "Invisible Children Project" of the National Mental Health Association (NMHA), released in November, 1988, highlights the fact that approximately 5,000 children are being placed out of their own state, and 22,000 children are being placed in state hospitals within a one year period. As the NMHA report indicates, not all of these placements are inappropriate. However, the experience of a number of states indicates that there are a variety of strategies for reducing these types of placements, and insuring that they are restricted to youngsters for whom there is an absolute need. This edition of Program Update builds on the findings of the Invisible Children Project to briefly review some of these developments.

There are a number of strategies that states have used for developing alternatives to residential placements. These strategies are not mutually exclusive and can be used in combination with each other. They include the following:

- Developing New Services
- Modifying Fiscal Incentives
- Establishing Stricter Gatekeeping Mechanisms
- Increasing Accountability
- Development of Policies/Statutes
- Modifying Attitudes and Beliefs

Developing New Services

One of the first and most influential demonstrations that most youngsters can be served within a community-based system took place in North Carolina in the aftermath of a class action lawsuit known as "Willie M. et al. v. James B. Hunt, Jr. et al.," filed in 1979. As a result of the settlement of this suit, North Carolina developed a broad range of community-based services targeted specifically at "seriously emotionally, mentally, and neurologically handicapped children and adolescents who are also violent and assaultive" (Behar, 1985).

The approach developed in North Carolina emphasized that "the full continuum of care must be in place," and "individualized treatment and educational planning, with broadly defined case management as the backbone is essential to the success of the service system" (Behar, 1985). After four years of program development, North Carolina found that only 6.8% of this very severe population needed to be served out of their region and in secure settings (Behar, 1985).

A recent report on this program from a psychiatric perspective concludes that "the North Carolina Willie M. program is a significant social experiment that is demonstrating that through the provision of adequate resources, the majority of chronically mentally ill, violent youth can be provided meaningful, stabilizing supportive community care" (Keith, 1988).

The emphasis on individualized treatment was carried to an even greater extreme in bringing children back from out of state placements in Alaska. This multi-agency effort, called the Alaska Youth Initiative (AYI), emphasizes the conducting of an intensive environmental assessment for each youngster, and the development of a highly individualized treatment plan (VanDenBerg, 1988). The individualized nature of the treatment is a major hallmark of the success of this program which, over a three year period, has brought back from out-of-state or prevented placement for 50 youngsters. This is done not by simply "placing" youngsters closer to home, rather it is done by developing individualized service approaches for each child.

The AYI is having an impact outside of Alaska as well. For example, Washington State is in the process of developing an initiative modeled after the creative programming efforts of the AYI and the Kaleidoscope program in Illinois. In a Request for Proposals recently issued by the Washington Department of Social and Health Services, an emphasis is placed on individualized programs that provide unconditional care, normalized care, include families, and offer an habilitation focus.

"Individualized treatment and educational planning, with broadly defined case management as the backbone is essential to the success of the service system"

– Lenore Behar, 1985

A multi-agency effort to divert youngsters from residential treatment through providing a coordinated range of services has had success in Ventura County, California (Ventura County, 1986) and will soon be extended to other areas of the state.

Within the 1980s there has been considerable progress in the development of particular service models that have applicability to efforts to keep children in their family, or in a family type of situation, if at all possible. Many of these have been reviewed in earlier issues of Update *(Home Based Services, Day Treatment, Therapeutic Foster Care, Case Management, Crisis/Emergency Services, and Individualized Approaches)*, and were highlighted at the summer, 1988, Training Institutes in Boulder, Colorado, sponsored by the Child and Adolescent Service System Program (CASSP) (see article, page 11). Each of these approaches, when embedded in an integrated system, appears to have the potential to eliminate the need for restrictive residential placements for some youngsters, and to insure that those youngsters who end up in such placements genuinely need them.

For example, after reviewing the evaluation findings on home-based services recently as part of the CASSP, Stroul concluded that "greater availability of these services will enable many troubled children to remain with their families and will ensure that those children placed in residential treatment settings truly need to be there" (1988).

Similarly, in a review of crisis services Goldman concludes that "increasingly, other alternatives (to inpatient psychiatric hospitalization) that provide treatment to youth in crisis are being viewed as therapeutically effective, more appropriate for serving children and adolescents, and less costly" (1988).

There are several models that have been developed that specifically look at the balance of services in the intensive non-residential components compared to the residential components (Behar, Holland, & MacBeth, 1987; Friedman, 1987). These models emphasize the need for a greater capacity in intensive non-residential components, if the inappropriate use of residential placements is to be reduced.

Modifying Fiscal Incentives

Within an effective system of care, fiscal policies "should create incentives for effective, community-based systems of service" (Stroul & Friedman, 1986) rather than incentives for use of restrictive placements. In a system where the cost of placement in a state hospital is assumed by a state agency and is therefore "free" to the local community and the cost of community-based services are assumed by local agencies, then the fiscal incentive is towards state hospital placement rather than service in the community.

In their effort to bring youngsters back from out-of-state placements, the AYI got a commitment that they could use the money being spent on out-of-state placements for local services. They were then able to develop not only effective local services but also less expensive services (VanDenBerg, 1988).

In Vermont, a waiver was obtained from the Health Care Financing Administration (HCFA) to use Medicaid funds to provide home and community based services for youngsters who might otherwise require state hospitalization. This resulted in a marked decrease in the number of children in state hospitals (Update, 1987). Despite this, however, no other state waivers have been allowed and states that have liberal hospital coverage for children with emotional problems have seen their expenditures in this area grow rapidly.

New legislation passed in Ohio in 1988 seeks to gradually transfer funds used to manage state hospitals to community mental health boards (Update, Summer 1988). As this is done, placements in state hospitals for children and adults will cease to be "free" to the local communities. This is designed to place greater responsibility at the community level, to establish incentives for less restrictive and more cost-effective services, and to establish closer coordination between community and hospital services. With such a system in operation in Wisconsin for adults, some communities have shown major decreases in their use of state hospitals (Alpha Center, 1986).

"Greater availability of these services will enable many troubled children to remain with their families..."

– Beth Stroul, 1988

In Florida, most of the public funds available for residential treatments are decentralized and placed under the control of the 11 service districts in the state. Since the money is their own to use under certain controls, each district has an incentive to be frugal so that it may get the largest benefit for its resources.

A second important fiscal issue, in addition to the types of incentives that are created by the funding policies, is funding flexibility. Most of the funding for mental health services in states has to be expended for particular categories of service, e.g, day treatment, or placement in a residential treatment facility. This produces situations where a treatment team may wish to provide an in-home counselor for a family, for example, but where the only available money is for a slot in a day treatment or residential program. As a consequence, the youngster may end up in a program that is more expensive and less beneficial.

Some of the more promising innovations, such as AYI, the Kaleidoscope program in Chicago, the Willie M. program in North Carolina, and case management in Florida, emphasize the need for funding flexibility to provide the ability to genuinely individualize treatment, and to reduce the need for residential treatment (Update, 1986). The provision of flexible funding, with proper monitoring procedures, is an action that can provide improved services without costing any more (and possibly saving money).

Establishing Stricter Gatekeeping Mechanisms

According to the Invisible Children report, fewer than half of the 15 states surveyed on this issue had an interagency gatekeeping mechanism in place to screen children to insure that an out-of-home placement was needed and appropriate. Such a committee is an important protection for a child and family at the time a placement is being considered, and is also an important protection after a child has been placed, by periodically reviewing progress and assessing the need for such a placement (Stroul & Friedman, 1986).

In Florida such a committee operates in each of the service districts, and is closely coordinated with case management services. No child can be placed in a residential setting because of emotional problems with public money unless that committee has reviewed the situation and determined that the child in fact needs the service, and that less restrictive services have already been tried. This includes children who are dependent, delinquent, both, or neither.

In Nebraska, the Department of Social Services in 1987 developed a "Mental Health Review Team" to monitor the care of children placed in restrictive residential settings (Nichols, 1988). Within 30 days after its initiation, there was a reduction in the number of youngsters in restrictive residential settings from 89 to 59, with no child being removed against medical advice and all 30 youngsters being moved to less restrictive settings. Within a 12 month period, the number of youngsters was reduced by a total of 54 with very few youngsters requiring rehospitalization.

In many states, the procedure that is followed to determine whether a child needs residential placement because of emotional problems varies from agency to agency, or community to community. Given the importance of this decision in the life of the child and the family, and the substantial cost of residential placements, the establishment of consistent, careful, multi-agency gatekeeping mechanisms is an important protection.

Alternatives to Residential Treatment

Increasing Accountability

Another mechanism for reducing inappropriate placements involves careful data collection and community-based accountability. There is a long way to go in this regard, however. For example, the Invisible Children study found that "many states didn't know very much about their Invisible Children. They didn't know how many there were, where they were being treated, nor how much money was being spent on treatment."

In particular, even in instances where states are aware of the number of children placed in state hospitals or out-of-state, they do not always break this information down to identify the regions of referrals. Within an effort to develop a community-based system of care, such a breakdown is essential to increase community accountability and responsibility for their children.

The "Bring our Children Home" campaign in Florida in 1984 provided monthly data, presented very publically in the newsletter of the Florida Council for Community Mental Health, of the number of children in out-of-state placements per service district. Data were also included on the percentage of children placed out-of-state from each district in relation to the overall percentage of the state's population of children placed out-of-state (Dendy, 1988).

Such an approach allowed districts with few placements to get public acknowledgement while increasing public awareness of the districts with excessive placements. This simple use of data heightened accountability and contributed to the success of the effort.

Another approach to reducing placements in state hospitals and in out-of-state facilities is the development of formal statutes, mandates, or policies. Arkansas is an example of a state that recently received a legislative mandate to bring back all children from out of state. This mandate has been followed by a rapid reduction in such placements.

In Massachusetts in the mid 1980s, the Governor decreed that no adolescents would be on units with adults in state hospitals. This resulted in an assessment of each youngster in the state hospital to determine if he/she still needed to be there. As a result of the effort, not only were youngsters removed from units with adults but about one-third of the total group was placed in community settings.

In addition state policies about the use of residential placements, particularly out-of-state, are of symbolic value in providing a clear statement of values and philosophy. This is often a needed step before service changes are made.

Modifying Attitudes and Beliefs

Other important and yet intangible factors affecting the use of state hospitals and out-of-state placements include the attitudes and beliefs of key decision-makers about the relative effectiveness of such placements in comparison to some of the more intensive and individualized community-based alternatives. The belief in the value of restrictive residential placements in relation to community-based services is often extremely strong despite the absence of research support (Curry, 1986; Friedman & Street, 1985; U.S. Office of Technology Assessment, 1986).

The main approach that states are taking to modify these beliefs is to bring information about new service developments and research findings to the attention of decision makers and advocates. This is accomplished through a variety of methods: conducting conferences and workshops at which information on new developments is presented, distributing written information, and arranging consultation with experts in the field.

More and more, as interest in these issues grow, states are taking small delegations of critical leaders to visit communities in other states so that the new approaches can be observed directly.

Overall, there are a variety of approaches that states have taken and can consider in their efforts to reduce inappropriate placements of children in state hospitals and in out-of-state facilities. These approaches clearly include the development of new services but also include other important features such as examining gatekeeping mechanisms and fiscal incentives.

Without question there will always be a small number of youngsters who will require treatment in restrictive settings. The results of the Invisible Children study and the experience of many communities indicate, however, that there is considerable room for improvement through use of the procedures described here.

Alternatives to Residential Treatment References and Resources

Alpha Center. (1986). Redirecting State Dollars to Build Community-Based Mental Health Systems. Available from David Goodrick, Cosmos Corp., 1011 D St., SE, Washington, DC 20003.

Arkansas. Information available from Bill Underwood, Division of Children and Family Svcs. DHS, PO Box 1437, Little Rock, AR 72203.

Behar, L. (1985). Changing patterns of state responsibility: A case study of North Carolina. Journal of Clinical Child Psychology, 14, 188-195.

Behar, L., Holland, J., & MacBeth, G. (1987). Distribution of mental health service components and their costs within a comprehensive system for children and adolescents: The North Carolina Plan. Available from Dr. Lenore Behar, Dept. of Human Resources, 325 N. Salisbury St., Raleigh, NC 27611.

Curry, J. F. (1986). Outcome studies of psychiatric hospitalization and residential treatment of youth: Conceptual and research implications. Paper presented at annual meeting of the American Psychological Association, August, Washington, D.C.

Dendy, C. (1988). For information contact Chris Zeigler-Dendy, 821 Cramac Dr., Lawrenceville, GA 30245.

Florida. Information available from DeVon Hardy, HRS, Alcohol, Drug Abuse and Mental Health Program Office, 1317 Winewood Blvd., Tallahassee, FL 32399.

Friedman, R. M. (1987). Service capacity in a balanced system of services for seriously emotionally disturbed children. Unpublished manuscript, available from the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, 13301 N. 30th St., Tampa, FL 33612.

Continued on Page 16

Child and Adolescent Service System Program Update

By Judith Katz-Leavy

In Sept. 1988, the Child and Adolescent Service System Program (CASSP) announced the award of 12 new grants. These included three Capacity Building Grants to Arkansas, New Hampshire, and Utah; seven State-level CASSP Grants to California, Maryland, Missouri, North Carolina, Oregon, South Dakota, and Texas; and two Community-level CASSP Grants to Mississippi and Pennsylvania. With the announcement of the new awards, CASSP is now actively operating in a total of forty states.

In addition to the ongoing grant program, CASSP continues to expand the scope of its technical assistance efforts. The CASSP Minority Initiative (see article page 4) expects to publish in early 1989 Part I of a two volume publication conceptualizing a culturally competent system of care encompassing philosophy, principles and actual examples of culturally competent practices. Part II will be based on a national survey and will include descriptions of culturally competent services, program components, and delivery systems.

To help states in their efforts to plan, develop, and finance a coordinated system of care, CASSP in collaboration with the National Association of State Mental Health Program Directors sponsored a workshop on Sept. 14-15, 1988 on Medicaid funding for community-based mental health services for children and youth with severe emotional disturbances. The workshop focused on six specific options: clinic services, rehabilitation services, personal care services, home and community-based waivers, early and periodic screening, diagnosis and treatment, and case management. The CASSP Technical Assistance (TA) Center is preparing a workshop report.

Judith Katz-Leavy, Asst. Chief, Child and Family Support Branch, NIMH, addressing the CASSP Training Institute in Boulder, CO.

As part of the continuing effort to expand the "Families As Allies" momentum, CASSP made available, through the Portland Research and Training Center, $100,00 to support five statewide parent networking grants. The project's purpose is to promote the organization of parents of children with serious emotional disorders to provide support, acquire information about their children's illness, and learn to advocate. Awards were made to parent organizations in Hawaii, Montana, Minnesota, Virginia and Wisconsin.

Another offspring of the "Families As Allies" effort was the working conference held Dec. 10-11, 1988 in Washington, DC. The purpose of this meeting was to develop five year goals addressing key issues and to lay the groundwork for an ongoing national coalition of families, professionals and other citizens concerned with improving services for children and adolescents with serious emotional problems.

The High Risk Program within the Child and Family Support Branch (CFSB) continues to develop information and technical assistance materials related to homeless children/adolescents and to children at risk for HIV infection. A curriculum is now available from the Branch for use in training shelter personnel to work more effectively with homeless families. A description of various programs serving the homeless will be available by March.

In conjunction with the CASSP TA Center at Georgetown, the Branch commissioned the Child Welfare League of America to develop a set of recommended AIDS policies for residential care facilities. Another publication, soon to be available through Georgetown, includes the presentation from a June 1988 workshop which focused on AIDS prevention for children with serious emotional disturbances.

A September workshop on refugee children who had come from zones of violence was held to summarize what is known about the mental health needs of refugee children and to identify both service needs and research gaps. Conference proceedings are being developed through the CASSP TA Center.

Boulder Institutes Provide In-depth Training

Over 350 people from 46 states attended the Training Institutes on Community-Based Services for Severely Emotionally Disturbed Children and Youth held in Boulder, Colorado from July 25-28, 1988. Participants and faculty represented mental health, child welfare, juvenile justice, and education agencies as well as policymakers, advocates, and parents. Great interest was shown in learning how to develop more effective programs for emotionally disturbed children reported conference organizers Sybil Goldman and Beth Stroul, of the Georgetown CASSP Technical Assistance Center.

The Institutes went beyond typical workshops by providing in-depth, practical information on three types of innovative community-based services -- crisis services, home-based services and therapeutic foster care. Staff from eight programs served as faculty for the Institutes, with each program leading day-long sessions describing its program model and approach.

The programs providing Institute faculty include: Child and Adolescent Emergency Service and Respite House, South Shore Mental Health Center, Quincy, MA; Children's Crisis Intervention Services, Transitional Residence Independence Service (TRIS), Sicklerville, NJ; Family Advocate Project, Counseling Service of Addison County, Middlebury, VT; Family Network and Individual Residential Treatment, Lee Mental Health Center, Ft Myers, FL; Homebuilders, Behavioral Sciences Institute, Federal Way, WA; Huckleberry House, Columbus, OH; Pressley Ridge Youth Development Extension (PRYDE), Pressley Ridge Schools, Pittsburgh, PA; and Satellite Family Outreach Program, Kaleidoscope, Chicago, IL.

Information is available from CASSP TA Center, 3800 Reservoir Rd., NW, Washington, DC 20007.

CROSS COUNTRY UPDATE

GEORGIA

Unexpected new funding became available in FY '89, due to the development of a multi-year capacity building plan which contained a description of services and dollar amounts necessary for a comprehensive community-based system of care, and the efforts of a strong local advocacy group. The $450,000 allocation will give a seven county area, a 20 slot day treatment program, a 6 slot adolescent therapeutic group home and $5,000 for purchase of respite care. This total allocation is the first new funding for child and adolescent community-based mental health services in four years.

As part of its continuing efforts to promote parent/professional collaboration, Georgia CASSP will sponsor 8 regional one-day "Families As Allies" workshops. In each area, planning committees will develop an agenda and invite parents and professionals to attend. Psychoeducation centers will also be asked to participate as co-sponsors.

IDAHO

The Idaho CASSP project was transferred from the Bureau of Mental Health within the Division of Community Rehabilitation to the newly-formed Division of Family and Children's Services (FACS) within the Department of Health and Welfare. This relocation will allow CASSP project staff to expand the range of technical assistance services offered throughout the state.

Major CASSP activities include completing a Migrant Head Start Project, funded by CASSP and administered by the Idaho Migrant Council; improving mental health services to Head Start children and their families through the use of bilingual mental health professionals; working with foster parents to provide training, respite and support group assistance; and developing a regional training agenda for disseminating policy on the placement and monitoring of children in intensive community-based, residential and institutional treatment facilities.

The CASSP project staff were very pleased to have Bob Friedman, Beth Stroul, Barbara Friesen and Richard Vosler-Hunter at the national "Empowering Families' 88" conference held in Boise on October 17.

MINNESOTA

As Minnesota begins developing a child and adolescent mental health system, three major efforts are underway. Applications are currently being reviewed to fund county-level children's mental health projects beginning 1989. These projects will demonstrate how the CASSP model will work on a county level (both urban and rural) in Minnesota.

Minnesota is circulating the initial draft of its children's mental health legislative plan for statewide input. The plan will be presented to the Legislature in January, 1989. This effort will amend the 1987 Minnesota Comprehensive Mental Health Act to include the specific needs of children and is drafted from the CASSP model.

Needs assessment surveys are coming in from each of Minnesota's 87 counties. These surveys ask counties to describe their system of care, including service quality and availability.

MISSISSIPPI

Mississippi CASSP began its fifth year with particular attention paid to Family Empowerment and Minority Development. On-going CASSP activities involve facilitating the development of parent support groups and parent involvement networks. CASSP will target one county in each of its three regions to develop minority support and advocacy networks during the current grant year. A cross cultural training manual will be coordinated with the Division of Human Resources, within the State Department of Mental Health.

The 4th annual statewide Networking for Change conference was held Sept. 14 - 15, 1988, and was co-sponsored by CASSP. The conference focused on family-centered services delivery at local and state levels.

With a new NIMH grant, Mississippi CASSP plans to further develop the direct-service case management model to include services provided to youth exiting the Department of Youth Services' juvenile delinquent residential programs and the Department of Public Welfare foster care program. The purpose of the community level system development model is to demonstrate for three years the ability of a coordinated case management system to improve identified child problems, to enhance interagency cooperation on a continuing basis, and to demonstrate cost savings while providing quality case management services.

NEW JERSEY

New Jersey's Division of Mental Health and Hospitals recently announced a $1.6 million "Challenge Grant" initiative, designed to facilitate and encourage the development and expansion of county-based services for SED children and adolescents. Three grants will be awarded based on established categories which recognize the wide variety of population sizes between counties. These grants propose a "challenge" to counties to design and coordinate a system of care based on local needs, maximizing existing and potential fiscal resources from other child serving systems.

NEW YORK

This year New York State CASSP is funding the operation of 13 Family Support groups that will provide information/education, skills building, and support to families who have a child who is seriously emotionally disturbed. The groups will cover a number of topics from behavior management to advocacy. On Sept. 28, 1988, 24 parents and professionals participated in a 2-1/2 day train-the-trainers program. The training was conducted by the Mental Health Association in Ulster County and funded by CASSP. The Mental Health Association in Ulster County is also completing a training manual on the development and facilitation of parent support groups. This manual will soon be available to other CASSP states.

Landmark legislation was passed that will allow the state to grant awards to local governments to fund the establishment of community-based services for youth at 100% net deficit funding. This legislation will have a main impact on the development of mental health services for children with serious emotional disturbances and their families.

Governor Mario Cuomo called for the establishment of an Interagency Children's Task Force to look at: a) access to services; b) the planning process; and c)

capital improvements to children's facilities. One outcome of this task force is the development of an interagency Marshall Plan approach to revitalize distressed communities in New York State. Twelve communities are targeted for this initiative. CASSP welcomes the opportunity to collaborate with other state agencies to develop creative solution options for providing the wide range of services required by these at-risk communities.

OKLAHOMA

On September 23-24, 1988, Oklahoma CASSP participated in Oklahoma's 2nd Annual Families as Allies conference. NBC Nightly News covered this conference to film a story regarding respite care for children with severe emotional disturbances. Field Producer Richard Berman, and Correspondent Jennifer McLougan were impressed with the Families as Allies concept and overwhelmed by the lack of respite for families of children with emotional disturbances. The segment aired on November 12th.

RHODE ISLAND

The Department of Children and Their Families, Division of Children's Mental Health Resources has had as its goal since 1985 planning, implementing and monitoring of a system of care for children who are mentally ill. Present focus is on better coordination among state departments, inclusion of 3rd party insurers and increased community impact. Recent activities have involved development of a collaborative effort among local education authorities, community mental health services and the Department; development of Medicaid options for ambulatory outpatient treatment for children and youth; and obtaining state appropriations for staffing a residential counseling center.

VERMONT

In June 1988, the local and state interagency system which Vermont CASSP has developed and worked with for two years, was signed into law. Essentially, the new legislation, S165, mandates a coordinated delivery of services to children and adolescents who have a severe emotional disturbance (SED) and their families from the planning and budgeting process of the major departments to the individual plan of each qualified child or adolescent.

Vermont has made significant progress in the area of program development. In October, Vermont's Department of Mental Health was awarded a grant to provide respite care to families of children who are SED. Not only will respite services be developed statewide, there will also be training and evaluation of respite workers and program design.

Nine intensive family-based service programs now operate throughout Vermont as a result of additional state funding. It is hoped that funding for three additional programs will be allocated this year, creating intensive family-based services programs in each region of the state.

WEST VIRGINIA

The new CASSP Project Director for West Virginia is David Majic. Efforts are underway to expand the regional projects. The results will be a statewide parent advocacy organization that speaks as one voice, the development of a grassroots constituency, media campaign for children (anti-stigma, family preservation, children's rights, etc.), a health promotion project, public hearings, an annual Governor's Conference, plus three regional symposiums, and ten full-day workshops throughout the State.

A consultant has been hired by the State Council for Children's Services for one year to address interagency policies and procedures, to develop a statewide interagency tracking system and to address the need to reduce fragmentation in service delivery.

STATE CONTACTS:

Ron Caldarone
Assistant Director
Department of Children and Their Families
Division of Children's Mental Health Services
610 Mt. Pleasant Avenue
Providence, RI 02908

Caren Craine
CASSP Program Director
Office of Mental Health
44 Holland Avenue
Albany, NY 12229
(518) 474-8394

Carl J. Donaldson, Jr.
CASSP Project Supervisor
Department of Human Services
Division of Mental Health and Hospitals
13 Roszel Road
Princeton, NJ 08540
(609) 987-2005

Jody Lubrecht
CASSP Director
Dept. of Health and Welfare
Division of Family and Children's Services
450 West State Street, 10th Floor
Boise, ID 83720
(208) 334-5520

Dawne M. Mickle
Division of Mental Health, Mental Retardation and Substance Abuse
878 Peachtree Street, NE, RM 315
Atlanta, GA 30309-3999
(404) 894-6562

Tumutual Norton
CASSP Project Director
Department of Mental Health
Division of Children and Youth Services
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201
(601) 359-1288

Rock Richardson
CASSP Director
Oklahoma Youth Center
1200 East Main Street
P.O. Box 1008
Norman, OK 73070
(405) 364-9004

David O. Saenz
Director, Children's Mental Health Services Project
Behavioral Health Services
Department of Health
1800 Washington Street, East
Charleston, WV 25305
(304)348-0627

Sherry Schoenberg
CASSP Coordinator
Department of Mental Health
103 South Main Street
Waterbury, VT 05676
(802) 241-2609

Joan Sykora
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, MN 55155-3828
(612) 296-7905

RESEARCH UPDATE

Learning Disabilities

The report to the U.S. Congress of the Interagency Committee on Learning Disabilities calls for a new definition of learning disabilities, and more emphasis on multidisciplinary research.

As a result of its work, the Committee estimates that 5 to 10% of the U.S. population is affected by learning disabilities, and that prevalence is somewhat higher among socioeconomically disadvantaged populations, and higher in males than in females. The Committee proposed a revised definition of learning disabilities to focus more on social skills deficits, and to indicate that attention deficit disorder may accompany learning disabilities. However, the Committee representative from the Department of Education dissented from this recommendation on the basis that such a change might affect eligiblity requirements under the Education of All Handicapped Children Act.

The Committee called for more coordinated multidisciplinary research, one goal of which would be the development of a classification system that clearly distinguishes between learning disabilities, attention deficit disorders, and conduct disorders.

The report by the Interagency Committee on Learning Disabilities, entitled *A Report to the U.S. Congress* (1987) is available from the National Institutes of Health, 9000 Rockville Pike, Bethesda, MD 20892.

Preventing Teenage Suicide

Efforts to prevent teenage suicide are reviewed in a recent article by David Shaffer and his colleagues in the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Shaffer indicates that the rate of suicide in 1984 for all 15-19 year olds was nine deaths per 100,000 population. As a result of this relatively low rate, he suggests that preventive efforts targeted towards high-risk groups may be "a more efficient strategy" than efforts directed to the general population.

He concludes that the research findings on general educational programs do little to support their value. "Most students do not need them, and those who do would probably be better served by an individualized approach to their clinical problems," according to Shaffer.

While reaching this conclusion, Shaffer indicates that "it is too soon to draw closure on suicide prevention," and that efforts should be directed towards focused, high-risk interventions, and towards gaining increased knowledge of specific risk factors.

"Preventing Teenage Suicide: A Critical Review", by David Shaffer, Ann Garland, Madelyn Gould, Prudence Fisher, and Paul Trautman, *Journal of the American Academy of Child and Adolescent Psychiatry*, 1988, 27:675-687.

Social Supports and Mental Illness

A special section of the *American Journal of Psychiatry* reviews research on the relationship between social supports and mental illness. The guest editor for this section, Marc Galanter, indicates that while it seems intuitively correct "that our emotional well-being is affected by the support of people close to us," only in recent years has the research been done to demonstrate "the way social supports are relevant to the course and treatment of mental illness."

Galanter concludes in his editorial on the special section that "we have reached a point where patients' treatment plans should be individualized to include assessments of their social networks and the steps that may be taken in collaboration with community resources to address observed deficiencies." He indicates further research is needed to test out the efficacy of various approaches for strengthening social support networks.

The special section is published in the October, 1988 edition of the *American Journal of Psychiatry*, 145:1248-1270.

Cost-Benefit in Special Education

The potential value of benefit-cost analysis in special education is discussed and illustrated in a recent article by Darrell R. Lewis. The value of this approach is illustrated in a follow-up study of students classified as mildly retarded and who completed at least 12 years of education in a suburban school district in Minnesota.

The results of the study indicate that "with appropriately identified, measured,and valued costs and benefits, it is possible to employ a formal benefit-cost framework to assess the efficiency of special education services." The model takes into account not only benefits and costs that can be clearly given a monetary value but also other benefits including increased self-sufficiency, self-esteem, and quality of life.

The authors conclude that while the most promising applications of this framework involve comparisons of alternative treatments, particularly where random assignment to conditions has taken place, the model can be employed with other types of comparisons as well.

The article is entitled "Using Benefit-Cost Analysis in Special Education," by Darrell Lewis, Robert Bruininks, Martha Thurlow, and Kevin McGrew, and is published in *Exceptional Children*, 1988, 55:203-214.

RTCCMH Studies Available

Early results of a six-state study of children identified as seriously emotionally disturbed either by the public mental health or school system are now available. The study is being conducted by the Research and Training Center for Children's Mental Health at the Florida Mental Health Institute, and the precise titles of the manuscripts are listed in the resource section (page 15).

The first papers provide general descriptive information on measures of intellectual and educational functioning, emotional and behavioral problems, and adaptive behavior. They also present a description of the major diagnoses of the youngsters, based on the administration of a structured psychiatric interview for children (DISC). Findings on family cohesion and adaptiveness, as perceived both by the youngsters and their parents, are also presented.

JUST AVAILABLE

A monograph on *Improving Practice Technology for Work with High Risk Families: Lessons from the "Homebuilders" Social Work Education Project* has just been released.

Order from: Monograph, University of Washington, School of Social Work, JH-30, 4101 15th Avenue, NE, Seattle, WA 98195.

Price: $10.

RESOURCES UPDATE

Research and Training Center for Children's Mental Health

The Research and Training Center for Children's Mental Health (RTCCMH) of the Florida Mental Health Institute is funded by the National Institute of Disability and Rehabilitation Research and the National Institute of Mental Health. The RTCCMH mission is to improve services for children with emotional disturbances and their families by increasing the knowledge base for such services. As part of its commitment to this mission, RTCCMH provides a variety of training, consultation, and dissemination activities.

Recent publications by the RTCCMH staff include:

#503 Service Trends in the Children's Mental Health System: Implications for the Training of Psychologists, September 1988.

#504 The Role of Therapeutic Foster Care in an Overall System of Care: Issues in Service Delivery and Program Evaluation. January, 1988.

#505 Characteristics of Children with Serious Emotional Disturbances Identified by Public Systems December, 1988.

#506 The Diagnostic Interview Schedule for Children: A Study of Its Utility with Children and Adolescents Identified as Emotionally Disturbed by Mental Health and Special Education Systems. December, 1988.

An Annotated Bibliography describing papers prepared by RTCCMH staff is available upon request.

Copies of material or further information can be obtained from Dr. Al Duchnowski, Director of Training, Consultation and Dissemination, RTCCMH, 13301 Bruce B. Downs Blvd., Tampa, FL 33612, (813) 974-4500.

Minority Children Services

The New Jersey CASSP Program released the proceedings from a 1987 planning session, "Developing Mental Health Services for Minority Youth and Their Families." These proceedings present an overview of the special needs of culturally diverse, ethnic minority groups. The workshop participants, in strategizing ways to affect change in the service delivery system, identified an Action Plan of specific tasks to be undertaken by the CASSP staff. Available from: Bureau of Children's Services, Division of Mental Health and Hospitals, N.J. Department of Human Services, CN 700, Trenton, NJ 08625.

Keeping Indian Families Together

A Special Issue of the *American Indian Newsletter* is devoted to developing the potential of family-based placement prevention services for American Indians. The issue discusses the need for preventing placements and the relevance to Indian child welfare, an overview of family preservation services with specific project examples, as well as policy issues relating to Indian families.

Available from the American Indian Law Center, P.O. Box 4456 - Station A, Albuquerque, NM 87196.

Homeless Training curriculum

A "Training Curriculum on Helping Homeless Families" has been prepared by Lorence A. Long for the National Institute of Mental Health. The training manual provides a comprehensive review of this social problem, methods for working with homeless families, and approaches to working within organizations and communities. The curriculum is available from: Jean Garrison, Ph.D., Child & Family Support Branch, NIMH, 5600 Fishers Lane, Room 7C-14, Rockville, MD 20857.

Networking Guide

A guide on networking mental health services for children and adolescents has been prepared by the Illinois Joint Services Children's Initiative (JSCI). Sponsored by the Illinois Department of Mental Health and Developmental Disabilities and the Department of Children and Family Services, this guide discusses the collaborative experiences of nine state agencies.

This guide was prepared by Robin M. Crane and is entitled "Our Children Deserve the Best: A Guide to Networking in Mental Health and Human Services for Children and Adolescents." Available from Ken Wade, Illinois Dept. of Mental Health, 401 Stratton Bldg, Springfield, IL 62706.

CASSP Monograph Series

A monograph series on providing community-based services to children and adolescents with serious emotional disturbances is being prepared by the CASSP Technical Assistance Center. Volume I: Home-Based Services and Volume II: Crisis Services are currently available ($10 each) from the CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Rd., NW, Washington, DC 20007. Volume III: Therapeutic Foster Care and Volume IV: Systems of Care are in preparation and will be available in the future.

RWJ Special Report on Handicapped

"Serving Handicapped Children: A Special Report" summarizes the findings of a 5-year Collaboration Study of Children with Special Needs conducted by the Robert Wood Johnson Foundation(RWJ). The study shows that the procedural guarantees of PL 94-142 are indeed in place; that health and related services are available although collaboration with non-school medical providers is weak; and that there are some positive indicators on the effectiveness of special education.

The Report is available from RWJ Communications Office, P.O. Box 2316, Princeton, NJ 08543-2316.

This newsletter is prepared by RTCCMH staff to provide information about developments in services for children with emotional disturbances and their families. We invite you to reproduce the material and distribute the information in any way you wish for the purpose of increasing knowledge about needs and services in children's mental health.

We ask you to acknowledge the source, and let us know how you used it. Thanks!

National Agenda

Continued from page 1.

coalition building versus establishing a separate national organization, the group agreed to continue meeting for the purpose of developing a national organization.

A small steering committee composed of parents was formed and accepted the task of arranging the next meeting. Marge Samels of Kensington, MD agreed to serve as interim coordinator and Dr. Ann Turnbull of the Beach Center, University of Kansas, agreed to be facilitator for the next meeting. Dr. Barbara Friesen of the Portland Research and Training Center was appointed to the steering committee and can be contacted for further information at P.O. Box 751, Portland, OR 97207, (503) 464-4040.

Invisible Children

Continued from page 1.

served as effectively in their own home community if appropriate community services had been available."

Dendy emphasizes the "importance of advocacy to bring about service change," and that alternatives to these placements for many youngsters "are definitely available" in terms of the state of knowledge in the field.

The report recommendations emphasize the development of comprehensive, balanced, systems of community-based care. The report also recommends the development of "gatekeeping mechanisms" with formal committee structures to determine the appropriateness of placement of children in out-of-home treatment facilities, the implementation of case management systems, and the development of flexibility in the use of funds.

Other recommendations call for states to develop specific plans to bring children home from state hospitals and out-of-state placements, the implementation of better data and monitoring systems, and expanded advocacy efforts.

Information on the report can be obtained from NMHA, 1021 Prince Street, Alexandria, VA 22314-2971. In addition to the report, a poster summarizing the findings is available.

References and Resources

Continued from page 10.

Friedman, R.M., & Street, S. (1985). Admission and discharge criteria for children's mental health services: A review of the issues and options. Journal of Clinical Psychology, 14, 229-235.

Goldman, S. K. (1988). Series on community-based services for children and adolescents who are severely emotionally disturbed: Volume II: Crisis services. Available from the CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road, N.W., Washington, DC 20007.

Kaleidoscope. Information available from Karl Dennis, 1272 N. Milwaukee, Suite 250, Chicago, IL 61701.

Keith, C. R. (1988). Community treatment of violent youth: Seven years of experience with a class action suit. Journal of the American Academy of Child and Adolescent Psychiatry, 27, 600-604.

Massachusetts. Information available from Joan Mikula, Asst. Commissioner for Child-Adolescent Svcs., Dept. of Mental Health, 160 N. Washington St., Boston, MA 02114

National Mental Health Association (1988). Invisible Children. Available from the National Mental Health Association, 1020 Prince St., Alexandria, VA 22314.

Nichols, M. J. (1988). Management of restrictive levels of care for children and adolescents - The Nebraska experience. Available from M. J. Nichols, Medical Services Division, Nebraska Department of Social Services, P. O. Box 95026, Lincoln, Nebraska 68509-5029.

Stroul, B. A. (1988). Series of community-based services for children and adolescents who are severely emotionally disturbed: Volume I: Home-based services. Available from CASSP Technical Assistance Center (see address above under Goldman).

Stroul, B. A., & Friedman, R. M. (1986). A system of care for severely emotionally disturbed children and youth. Available from CASSP Technical Assistance Center (see address above under Goldman).

Update (1987) Report presents data on state Medicaid practices. 3, 1:5. Additional information on Vermont's Medicaid waiver available from John Pierce, Dept. of Mental Health, 103 S. Main St., Waterbury, VT 05676.

Update (Summer, 1988). Ohio deals with CON change. 3, 2:6. Information on Ohio's change is available from Patrick Kanary, Bureau of Children's Services, Dept. of Mental Health, 30 E Broad St., 11th Floor, Columbus, Ohio 43215.

Update (1988). Individualizing services. 3, 2:10-12. Copies of previous Update articles on program developments are available from the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, 13301 N. 30th St., Tampa, FL 33612.

U.S. Office of Technology Assessment (1986). Children's mental health: Problems and services--A Background paper. Washington, D.C.: U.S. Government Printing Office.

VanDenBerg, J. (1988). Personal communication. Information available from Division of Mental Health and Developmental Disabilities, Box H-04, Juneau, AK 99811.

Ventura County Children's Mental Health Demonstration Project. Information available from Randall Feltman, 300 Hillmost Ave., Ventura, CA 93003.

Washington State. Information available from Richard Westgard, Dept. of Social & Health Services, Mail Stop OB-42F, Olympia, WA 98504.

UPDATE

Research and Training Center for Children's Mental Health
Florida Mental Health Institute
13301 Bruce B. Downs Boulevard
Tampa, Florida 33612-3899
813/974-4500

Non-Profit Org.
U.S. POSTAGE PAID
at Tampa, Florida
Permit No. 257

Events, activities, programs, and facilities of the Universtity of South Florida are available to all without regard to race, color, sex, religion, national origin, Vietnam or disabled veteran status, handicap, or age, as provided by law and in accordance with the University's respect for personal dignity.

This public document was promulgated at an annual cost of $20,560 or $.51 per copy including preparation, printing, and distribution, to provide information about mental health services for children and the activities of the Research and Training Center for Children's Mental Health, FMHI, USF. [89-54]

BEST COPY AVAILABLE

Florida Mental Health Institute, University of South Florida, Tampa, Florida

UPDATE

Improving Services for Emotionally Disturbed Children

VOLUME 5, NUMBER 1 SUMMER 1989

Governors Issue a Call for Commitment to Children

The National Governors Association (NGA) declared, at their meeting in Chicago in July, 1989, that a commitment is needed to translate existing knowledge about emotional disorders "into an effective system to assist these children and their families in a comprehensive manner."

A policy statement based on a 1989 study was approved, according to Richard Jensen of NGA. The study was conducted by the Human Resources Committee of NGA under the leadership of Governor Richard Celeste of Ohio.

"The National Governor's Association is deeply concerned with the issue of children's mental health in this country," Celeste said. "There is a critical need to promote and develop a real system of care for children with serious emotional disturbances. Parents and families of seriously disturbed children care about what happens to their kids, and need to be included in all levels of program and treatment planning. The NGA supports a more coordinated and integrated system of care for this country's youth so that they have every opportunity to lead full and productive lives."

Governor Richard Celeste of Ohio, Chair of NGA Human Resources Committee.

The policy indicates that, "Major changes are needed to change the focus of state program structures so that they are child-centered and family focused. This simple, but often overlooked, principle will require states to re-evaluate their policies, program planning and funding mechanisms in order to meet the complex and changing needs of individual children and their families, including the specific needs of minority and culturally diverse populations."

The statement calls for a broad array of community-based treatment alternatives, with a special focus on therapeutic

Continued on Page 24.

Institute of Medicine Releases Report on Research

Expressing "excitement about the demonstrable progress occuring in many segments of child mental health research," in June, 1989, the Institute of Medicine (IOM) of the National Academy of Sciences released its report entitled, "Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders."

The report was requested by the National Institute of Mental Health (NIMH) in June, 1988, and was prepared by a 17-person IOM committee, chaired by Dr. James Leckman of Yale University, with Dr. Glen Elliott of the University of California at San Francisco serving as Vice-Chair.

The report proposes a national plan that is intended to be capacity-building in nature, and "focuses on three interrelated areas: the need to develop viable and attractive individual careers in child mental health research; the need to encourage and support programmatic research at the frontiers of scientific inquiry; and the need to enhance NIMH's ability to provide sustained leadership in the area."

Overall, the plan calls for an increase in the recommended NIMH budget for research, training and support in child mental health from a present annual level of $52.2 million to $111 million during the first year of the plan, and $198.5 by the fifth year of the plan. In calling for such an increase, the IOM committee indicated that while it was excited about prior progress in the field, "it was impressed that advances in the field and in related specialties hold promise of even more impressive gains in the near future."

Dr. Lewis Judd, NIMH director, hailed the report as a "pathbreaking examination of research needs and opportunities." He indicated as well that "progress within the past two decades has been considerable, and the field is now ready to advance rapidly. I am committed to seeing that those advances occur."

Continued on Page 24.

NEWS UPDATES

RWJ Grants	3
Congressional Spouses	3
Education Legislation	4
New Parent Organization	5
Center Funding	7
Invisible Children	11

DEPARTMENT UPDATES

CASSP	6
Cross Country	8
Program Update	12
Research Analysis	20
Resources	22

RESEARCH AND TRAINING
CENTER FOR CHILDREN'S
MENTAL HEALTH

UNIVERSITY OF SOUTH FLORIDA
FLORIDA MENTAL HEALTH INSTITUTE
13301 Bruce B. Downs Boulevard
Tampa, Florida 33612-3899
(813) 974-4500

ADVISORY BOARD MEMBERS

CHRISTINA K. YOUNG, CHAIRPERSON
Salem, Ohio
COLLEEN L. F[illegible]IS
Tampa, Florida
ADLAI BOYD, Ph.D.
University of South Florida
Tampa, Florida
ROBERT E. BRABHAM, PH.D.
National Rehabilitative Association
Alexandria, Virginia
WILLIAM BUZOGANY, M.D.
Mendota Mental Health Institute
Madison, Wisconsin
KARL W. DENNIS
Kaleidoscope
Chicago, Illinois
ELINOR ELFNER, PH.D.
Bureau of Education for Exceptional Students
Tallahassee, Florida
DAVID FANSHEL, D.S.W.
Columbia University School of Social Work
New York, New York
JEWELLE TAYLOR GIBBS, PH.D.
University of California
Berkeley, California
MARIO HERNANDEZ, PH.D.
Pioneer School
Camarillo, California
MAREASA ISAACS, PH.D.
Commission of Mental Health Services
Washington, D.C.
RON LANEVE, ED.D
Rockville, Maryland
BRENDA LYLES, PH.D.
Quality Assurance Monitoring Group
New Orleans, Louisiana
LORELLA A. MCKINNEY, PH.D.
Columbus, Ohio
JO M. PINE, M.S.W.
Mental Health Association
Baton Rouge, Louisiana
HERBERT C. QUAY, PH.D.
University of Miami
Coral Gables, Florida
BARBARA STARFIELD, M.D., M.P.H.
The Johns Hopkins University
Baltimore, Maryland
MURIEL THOMPSON
Wilson, North Carolina
LUDIE WHITE, M.S.W.
Durham, North Carolina
CHRIS A. ZEIGLER-DENDY
Mental Health Association
Decatur, Georgia

U.S.F. ADVISORS
RICHARD DEMBO, PH.D.
WILLIAM EMENER, PH.D.
RAYMOND HILL, ED.D.
LEE HUSTING, PH.D.
AUGUST MAUSER, ED.D.
CALVIN PINKARD, PH.D.
ARCHIE SILVER, M.D.

CONSULTANTS
LENORE BEHAR, PH.D.
North Carolina Department of Human Resources
Raleigh, North Carolina
TONY BROSKOWSKI, PH.D.
Preferred Health Care, Inc.
Miami, Florida
LARRY DIAMOND, PH.D.
SENIOR SHARE
Cambridge, Massachusetts
JANE KNITZER, ED.D.
Bank Street College of Education
New York, New York
JUDITH TOLMACH, A.C.S.W.
Washington, D.C.
KAREN UNGER, PH.D.
Boston University
Boston, Massachusetts

CENTER STAFF
ROBERT M. FRIEDMAN, PH.D.
Executive Director
ALBERT DUCHNOWSKI, PH.D.
Director, Training, Consultation, & Dissemination
STARR SILVER, PH.D.
Director, Research
KRISTA KUTASH, M.B.A.
Administrative Director
ALISSA ALGARIN, B.S.
UPDATE Editor
KELLY ENDOR
Assistant Editor

CENTER PROJECT FOR CHILD WELFARE-
CHILD MENTAL HEALTH COLLABORATION
SUSAN YELTON, M.S.W.
Director

DIRECTOR'S UPDATE

By Bob Friedman

Five years ago, we were very fortunate at the Florida Mental Health Institute (FMHI) to receive a grant from the National Institute on Disability and Rehabilitation Research and the National Institute of Mental Health (NIMH) to establish a research and training center.

This summer we received the good news that we have been funded for five more years. We are excited and delighted with this news. During the past five years, we have worked with a network of talented and dedicated individuals from across the country to address important issues confronting children and families. Personally I have had the good fortune to work with a wonderful Center staff, a supportive administration at FMHI, and a very committed group of Center advisors and consultants.

We look forward to continuing to work with people in all capacities from across the country who share a commitment to troubled children and their families. We invite you to call or write us if we can be of any assistance.

Much as the Center completes its fifth year of operation, so, too, this is the fifth birthday of CASSP -- the Child and Adolescent Service System Program of NIMH. In recognition of the tremendous importance of CASSP, we have included a four page section on CASSP (pages 16-19).

First, I would like to wish CASSP a Happy Fifth Birthday, and commend it on what I consider to be an enormous set of accomplishments in a relatively short time period with very limited funds. Second, I would like to especially thank and congratulate Ira Lourie and Judith Katz-Leavy of NIMH along with others such as Jim Stockdill and Judy Jacobs who have provided outstanding leadership for CASSP since its inception.

Third, I would like to briefly list what I consider to be the major accomplishments of CASSP.

- There has been an increased recognition that services for children with serious emotional disturbances and their families have been greatly lacking;
- There has been a major conceptual shift in the thinking about service needs for this population. Specifically, there has been a movement to recognize the need for community-based, multi-agency systems of care, and an increasing focus on developing individualized service approaches;
- There has been significant progress in re-defining the role of parents and considerable movement to empower parents to act both on behalf of their individual children, and on behalf of the larger group of children and families in need of service;
- There has developed a tremendous network of information-sharing;
- The base of knowledgeable leadership has grown enormously.

There are certainly other important accomplishments of CASSP as well as areas in which progress has been less striking. The overall record is clear to me, however. This five year old child called CASSP, from a developmental standpoint, has clearly been precocious. The next few years will be critical in determining if this foundation will serve as a base for important improvements, or if the growth that has been achieved so far will be gradually chipped away.

BEST COPY AVAILABLE

Robert Wood Johnson Grant Recipients Announced

Twelve states have secured a grant under a Robert Wood Johnson Foundation program that will generate up to $20.4 million in awards over the next five years. The program encourages multi-agency, state-community partnerships to improve services for children and youth with serious mental illness.

The twelve sites approved by the foundation's Board of Trustees in July, 1989, are California, the District of Columbia, Kentucky, Michigan, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Washington, Wisconsin and Vermont.

The states approved will receive a one-year $100,000 development grant to begin their program, said Michael Beachler, program officer for the foundation.

The national program office, directed by Mary Jane England, M.D., will provide technical assistance to the sites.

During the first year, the states will be expected to secure matching funds, obtain any necessary statutory authority, develop interagency agreements and develop refined work plans for the integrated system.

In July of 1990, up to eight of the participating states will be chosen to receive four-year grants of up to $2.4 million to implement their programs.

"We were really pleased with the quality and variety of proposals submitted," Beachler said. "There are a lot of agencies that care for these youth and a lot of people willing to work together and pool resources across categorical lines."

The proposals and workplans of the states chosen have a number of common features, Beachler said. Most states have proposed to reduce the number of residential placements, increase the range and number of community based services and improve the statewide financing mechanisms for providing services.

Many of the states also plan to develop centralized intake units for all systems that serve these children, such as child welfare, mental health, special education and juvenile justice, and to unify the client tracking process across those systems. The sites also plan to let the client's needs guide their efforts and involve the families as advocates for change in the systems.

All the states plan to use a multiplicity of financing strategies including expansion of the use of Medicaid, and creation of new state or local funding over the next five years. A number of states also plan to blend the resources of various agencies, use private insurance enhancement strategies and reallocate existing state funds from institutional care to community-based services.

Beachler stressed that cooperation between the various agencies and different levels of government is a central part of this program. "It is not just a state initiative, but a state and community partnership," he said.

The states were chosen by the foundation with assistance from a 12-member National Advisory Committee chaired by former governor James Hunt of North Carolina.

For more information on the program contact Dr. Mary Jane England, Prudential Insurance Company, 56 N. Livingston Ave., Roseland, NJ 07068 (201) 716-6882.

Congressional Spouses Hold Child Mental Health Conference

Declaring that progress in mental health services for children has seriously lagged behind progress for adults, a bipartisan group of Congressional spouses conducted its first educational conference on "Child Mental Health Policy and the 101st Congress," in Washington, D.C. on June 8, 1989.

The group of Congressional spouses is chaired by Tipper Gore and consists of ten spouses who have adopted children's mental health as a special concern. The conference was co-sponsored by the National Mental Health Association (NMHA), and many other professional organizations.

The conference followed the release earlier in the week of the findings of the NMHA's "Invisible Children Project," and the National Academy of Science's (NAS) report on research needs in children's mental health. Ann Ince presented a summary of the findings of the NMHA study while Dr. Joseph Coyle gave an overview of the NAS recommendations.

Dr. Lewis Judd of the National Institute of Mental Health made a presentation on the causes of mental disorders. A family perspective was offered by Barbara Huff, Kristin Huff and Mary Jo Quinlan. Dr. Jane Knitzer of Bank Street College of Education presented on service needs.

Reporters from Children's Express, a group of children and adolescents who cover news as it impacts youth, followed each panel of presenters with questions.

Founding members of the NMHA's Child Mental Health Interest Group are Corrine Conte, Susan DeConcini, Nancy Domenici, Penny Durenberger, Tipper Gore, Barbara Johnson, Norma Lagomarsino, Alice Lancaster, Sharon Rockefeller, and Claudia Weicker.

Anne Ince, Chair of NMHA's Children's Committee and Tipper Gore, Chair of Child Mental Health Interest Group at June meeting.

The group met again on June 15 and decided to hold an educational luncheon series beginning this fall with a focus on specific mental health disorders and children's mental health.

Further information on the children's mental health conference or the group is available from Gina White, NMHA, 1021 Prince St., Alexandria, VA 22314-2971, (703) 684-7722.

Reauthorization of EHA Being Studied

A reauthorization of programs in the Education for the Handicapped Act (EHA) will feature a major emphasis on children with serious emotional disturbances (SED) as it is introduced into Congress, staff members of Senate and House subcommittees say.

Programs that were recommended by the National Mental Health and Special Education Coalition to help better educate children with SED have been incorporated into the legislation, said Chris DeGraw, staff member of the Senate Subcommittee on the Handicapped.

A rough draft of the legislation has been proposed and is expected to be presented to the House in September, said Pat Laird, staff member of the House Select Education Subcommittee. The House version will also use the Coalition's testimony to gear funds for programs to children and adolescents with serious emotional disturbances.

Chris Koyanagi, Director of Federal Relations for the National Mental Health Association (NMHA), said the legislative process is going more slowly than the association had hoped it would. "We're getting very impatient. We hope that the proposals of the coalition will be a part of the legislation."

Dr. Steven R. Forness presented the Coalition's proposal to the subcommittee in April, 1989. Forness is a professor and inpatient school principal at the Neuropsychiatric Institute and Hospital, University of California.

The Coalition asked for grants for studies of the status of special education, on how to reduce the use of out-of-community residential programs, on how to develop collaboration between agencies, on how to synthesize knowledge and disseminate the information and grants for projects to develop curricula. Priority should be given to projects that address the needs of ethnically and culturally diverse children and their families, Forness said. The Coalition asked for $15 million for these grants in federal fiscal year 1990.

The amount of funding had not been decided at press time and DeGraw said the Senate's decision on money for the grants will be based on funding available. Laird said the House will not grant the full $15 million requested by the coalition but there will be some funding for some of the programs suggested by the Coalition.

Children with SED are the most under-served population of students with handicaps. According to Forness, only about 19 percent of students with SED are currently being served under P.L. 94-142. P.L. 94-142 requires all states to provide a free and appropriate education to children who have a handicapping condition.

States and agencies vary in their interpretation of the federal definition of seriously emotionally disturbed, which many professionals consider to be a major factor in the under-identification of students with SED, Forness reported. Children with SED have the highest dropout rate and the lowest graduation rate of all children with handicaps in educational programs.

The Coalition also asked for at least one study to look at the use of out-of-community residential programs, the factors that influence such placements and the factors that facilitate or impede transition of students back to educational programs in their communities.

A full copy of the Coalition statement or an edited version of the testimony in the June, 1989, "NMHA Speaks" is available from the NMHA Public Policy Department at 1021 Prince Street, Alexandria, VA 22314 or call (703) 684-7722.

Study Complete on Medicaid Funding

The National Association of State Directors of Special Education (NASDSE) has conducted a survey of state agencies billing Medicaid for services for children with special needs. A report on the survey has been prepared by the University of Iowa and is currently at press.

A recent federal law made Medicaid available for educationally-related services to low-income, handicapped children, infants and toddlers. PL 10[illegible] the Medicaid Catastrophic Prevent[illegible] of 1988, provides federal Medicaid matching funds to reimburse services related to education even when those services are required under a handicapped student's individualized education program or a disabled infant/toddler's individualized family service plan.

The study looks at how states have used these new funding options, said Donald Kates, Financing Technical Assistance Coordinator at the Georgetown University Child Development Center.

The study can be ordered through the National Maternal and Child Resource Center, Law Building, University of Iowa, Iowa City, IA 52242.

Research Conference 1990

The Research and Training Center for Children's Mental Health of the Florida Mental Health Institute presents it's third annual research conference on "A System of Care for Children: Building A Research Base." The conference will be held February 12 through 14, 1990 at the Harbour Island Hotel in Tampa, Florida.

Scheduled speakers include Dr. Thomas Achenbach of the University of Vermont, Dr. Cliff Attkisson of the University of California at San Francisco, Dr. Len Bickman of Vanderbilt University, Dr. Barbara Burns of Duke University, Dr. Len Saxe of Brandeis University, and Dr. Jim Whittaker of the University of Washington.

Attkisson, Bickman and Saxe are scheduled to speak on the evaluation of large systems. Whittaker is to speak on evaluation of residential treatment and Achenbach will discuss the proper use of his instruments in services research. Burns will discuss service utilization in the children's mental health field and will participate in a panel on building supports for systems of care research.

Individuals interested in speaking or presenting a poster must submit a 300 word abstract by October 1, 1989 to Al Duchnowski, Director of Training, Consultation and Dissemination, RTCCMH, Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899. Speakers will be notified by November 30, 1989. Registration for the conference is $165. For more information, contact Ms. Kelly Enzor at the above address.

Conference Discusses System of Care for Minority Children

Approximately 150 legislators, agency administrators, parents and clients met and learned about culturally sensitive approaches for delivering mental health services during a conference entitled "Implementing a System of Care for High Risk Black and Latino Children and Youth" held June 1 and 2, 1989 in New York City.

"A system of care is strengthened when it accepts that the people it serves are from very different backgrounds and will make different choices based on culture," said Dr. Aminifu Harvey of the Maat Institute for Human and Organizational Enhancement.

Points brought out during the conference include the repercussions of a culturally insensitive system, the importance of working with the foster care system in a creative and culturally competent manner and the importance of matching culturally competent services to the specific client population.

Dr. Mareasa Isaacs, administrator of the Child/Youth Administration in Washington D.C., presented a framework for implementing a culturally sensitive system of care and Dr. Hope Hill, a division director with the administration, gave specifics on how to "put the system in place."

A delegation from each state conducted a self-assessment of their state's sensitivity to cultural differences and capacity to develop a comprehensive culturally competent system of care. The states had varying degrees of development along the culturally competent continuum.

The conference was sponsored by the National Institute of Mental Health; the Child and Adolescent Service System Programs of Brooklyn, Delaware, New Jersey, New York State and Pennsylvania; and the New York City Department of Mental Health and Mental Retardation and Alcoholism Services.

A summary of material from the workshops will be consolidated into a conference abstract. For more information contact Marva Benjamin, CASSP Technical Assistance Center, Georgetown University Child Development Center, 3615 Wisconsin Avenue NW, Washington, D.C. 20016 or call (202) 364-4164.

New Parent Organization Focuses on Youth and Families

A new organization with a focus solely on youth with emotional, behavioral or mental disorders and their families met on June 10, 1989. The Federation of Families for Children's Mental Health, the first national organization of its kind, adopted a set of by-laws and elected an interim slate of officers.

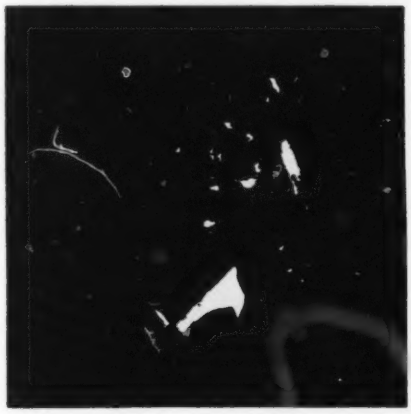
"Our only focus is children and adolescents and we intend to do some very intense lobbying on the federal and state level," said Barbara Huff of Kansas, president of the Federation. "In the past, there has not been enough of a focus on children and their families."

Huff said the lobbying efforts will push for community-based services in the least restrictive environment. Children should not have to fit into existing services, the services should meet the needs of the individual child, she said.

The group plans to focus on four areas: the lack of services available for children and adolescents with serious emotional problems; family support and family support services; the issue of parents having to relinquish custody to the state in order for their child to receive treatment; and the inability of special education and regular education to meet the needs of the children.

The Federation's plan is to develop a strong presence on the national scene and have a well developed network of state affiliates. Membership is solicited from parents, other family members, any caring private citizens and professionals as well as any organizations.

The group also plans to promote public education and awareness of the issues around children and adolescents with severe emotional disturbances.



Barbara Huff, President, Federation of Families for Children's Mental Health.

The Federation officers are: Huff, president; Glenda Fine of Pennsylvania, first vice president; Creasa Reed of Kentucky, second vice president; Marge Samels of Maryland, secretary; and Dixie Jordan of Minnesota, treasurer. The officers have been assisted by a steering committee of 20 people from 12 different states.

The group's first national meeting is set for November 11-12, 1989, at the Sheraton National in Crystal City, VA (a suburb of Washington, D.C.). Participants will be limited so early registration is advised. A larger national conference is also planned for April, 1990. The meeting and conferences are to be annual events.

For information on the Federation and the meeting in November, contact Federation of Families for Children's Mental Health, 1021 Prince Street, Alexandria, VA 22314-2971, (703) 684-7722.

Federation of Families for Children's Mental Health

Mission Statement

To ensure the rights to full citizenship, support and access to community-based services for all children and youth with emotional, behavioral, or mental disorders and their families.

To address the unique needs of children and youth with emotional, behavioral or mental disorders from birth through the transition to adulthood.

To provide information and engage in advocacy regarding research, prevention, early intervention, family support, education, transition services and other services needed by these children, youth and their families.

To provide leadership in the field of children's mental health and develop necessary human and financial resources to meet its goal.

Child and Adolescent Service System Program Update

by Judith Katz-Leavy

CASSP is finishing its fifth year and is in the process of studying the results of the first five years and setting directions for the future. Currently, CASSP is in 42 states. The process has been expanded down to the community level in many of the states and there are currently 11 local CASSP grants. The potential exists for all states to have grants by the end of this fiscal year. Fiscal year 1989 funding for CASSP is $9.8 million of which $1 million has been tapped to fund services research for the homeless.

Special emphasis is being placed on the evaluation of CASSP projects. There is a study currently in place looking at the results of the first ten state grants. In addition, extra monies have been made available for all grantees to compete for special evaluation additions to their CASSP projects.

New directions for CASSP in the next fiscal year include an increased emphasis on local extensions of the CASSP process and the development of a research program to study those service delivery questions which have grown out of the CASSP experience.

In the context of the CASSP goal of family involvement in services for children with severe emotional disturbances and their families, CASSP continues to work with several parent advoc[illegible]anizations. Through the Rese[illegible]nd Training Center at Portland State University five state-level parent support organizations have been funded. CASSP is working with NAM[illegible]MHA, and the new Federation [illegible] Families for Children's Mental Health to assure parental input into the planning process for children and adolescents.

The CASSP minority initiative has published a monograph entitled, "Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Severely Emotionally Disturbed." This study builds on the system of care as described by Stroul and Friedman in the monograph, "A System of Care for Severely Emotionally Disturbed Children and Youth." It will lead to a new study of the service components that demonstrate the principles of the culturally competent system of care to be done this coming fiscal year.

Homeless children and children in homeless families are also a special focus within CASSP grants. All new grants will have homeless objectives and old grants will be encouraged to include them in their upcoming plans.

Research Conference Addresses Service System Issues

A need for more scientific research in the field of children's mental health services and for empirical data to support policy decisions were the two predominant themes at the Second Annual Research Conference on Children's Mental Health Services, sponsored by the Research and Training Center for Children's Mental Health, at the Florida Mental Health Institute in Tampa, Florida in February, 1989.

Calling on the need for "new knowledge" in children's mental health research, Dr. Alan Leshner, Deputy Director of the National Institute of Mental Health (NIMH) reviewed the range of federal initiatives in this area. NIMH's own directives include emphasis on public agency-university collaborations, increased funding as a result of the block grant set aside for children's mental health and a major commitment to children's mental health services research.

Dr. Barbara Burns, of the University of Maryland's School of Medicine defined three separate but interrelated research issues that pose serious research challenges: over-use of inpatient and residential services which serve a relatively small number of children, under-use of mental health services by large numbers of children whose emotional problems are unrecognized, and the inadequate use of many mental health services by children in the mental health systems.

Dr. Alan Leshner, Deputy Director of NIMH, presents at Research Conference in Tampa.

She suggested that the forthcoming federal research funds for children's mental health -- nearly double the amount available in previous years -- be used to study these issues and resolve these discrepancies.

John VanDenBerg of the Alaska Division of Children's Mental Health cautioned participants not to forget the political realities of children's mental health services; that researchers must make their findings understandable and useful to administrators, legislators and taxpayers. Several parent advocates also expressed the need for researchers to communicate with parents about research findings.

Dr. Jane Knitzer of the Bank Street College of Education reported results of a national study on how public schools serve children with emotional problems. She stressed the importance of the mental health field taking a more active role in working with school systems.

Conference proceedings are being prepared and may be ordered from the Center. Next year's conference is scheduled for February 12 through 14, 1990 in Tampa. For information contact Kelly Enzor at the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899 or call (813) 974-4500.

BEST COPY AVAILABLE

Children's Mental Health Centers Funded

Starr Silver, Al Duchnowski, Krista Kutash and Bob Friedman of the Research and Training Center for Children's Mental Health at the Florida Mental Health Institute.

Three centers that have been conducting research, training, and technical assistance activities in children's mental health for the past five years, including the Research and Training Center for Children's Mental Health at the Florida Mental Health Institute, received federal grants this summer to continue their work for the next five years.

The other two programs are the CASSP Technical Assistance Center at the Georgetown University Child Development Center, and the Research and Training Center at Portland State University. The Center for Psychiatric Rehabilitation at Boston University, which focuses on adults, also received an additional five years of funding.

The Research and Training Center in Florida received $600,000 for the first year. The funding is jointly from the National Institute on Disability and Rehabilitation Research (NIDRR) and the National Institute of Mental Health (NIMH).

Dr. Bob Friedman, Center Director, was particularly pleased that the Center will be able to continue its six-state longitudinal study of children with serious emotional problems. The youngsters were between nine and 17 years of age during the first year of the study, and will now be followed up until they are between 16 and 24 years of age.

This Center will also study successful transition programs for older adolescents moving from school to work, will conduct a six-site study of alternatives to residential treatment, and will examine financing options to support community and home-based services.

The Technical Assistance Center is part of the National Network for Children with Special Needs and is funded jointly by the Office of Maternal and Child Health and NIMH. This Center, led by Dr. Phyllis Magrab, Director, Sybil Goldman, Deputy Director, and Ellen Kagen, Coordinator, will receive $500,000 for CASSP-related activities its first year.

The Research and Training Center at Portland State University, under the direction of Dr. Barbara Friesen, will receive $600,000 its first year from NIDRR and NIMH. This Center will focus specifically on issues related to the families of children with serious emotional disturbances.

For the Center at Boston University the new award marks its third consecutive five year grant. Under the direction of Dr. Bill Anthony, this Center will receive $750,000 its first year, also from NIDRR and NIMH. One unique research project will involve collaboration with the Florida Center to look at the service needs of older adolescents and young adults. Other research projects at the Boston Center will focus on case management and consumer involvement in service delivery.

Children's Plans Undergo Review

A striking feature of the children's mental health plans submitted by states to the National Institute of Mental Health (NIMH) in January, 1989 was the high degree of agreement on a general vision of what the ideal system of care should be like, according to Judith Katz-Leavy, of NIMH's Child and Family Support Branch.

The children's plans were submitted in response to Public Law 99-660, the Mental Health Planning Act, passed by Congress in 1986.

Katz-Leavy's comment was based on the initial review of state plans for children with serious emotional disturbances. The vision of the ideal system drew heavily upon the system of care monograph sponsored by NIMH and prepared in 1986 by the Georgetown CASSP Technical Assistance Center and the Research and Training Center for Children's Mental Health at the Florida Mental Health Institute.

According to Katz-Leavy, the process by which states developed their plans included far greater representation of parents than prior planning activities.

A meeting of representatives from five states (Nebraska, Ohio, Pennsylvania, Tennessee, and Virginia), NIMH officials, and staff from the National Association of State Mental Health Program Directors on February 28, 1989 identified issues for further examination from the plans.

These included the relationship of child mental health planning to the overall state mental health planning effort, strategies for financing services, the establishment of quantitative targets for a full range of out-of-home placements, the definition and provision of case management services, and the role of families and cultural differences in the design and implementation of services.

Revised plans are due by September, 1989. Further information is available from Maury Lieberman or Susan Salasin at the State Planning and Human Resources Development Branch of NIMH, 5600 Fishers Lane, Room 7-99, Rockville, MD, 20857 or call (301) 443-4257.

CROSS COUNTRY UPDATE

ARIZONA

Two children's bills acknowledging the need for a coordinated comprehensive continuum of behavioral health services were passed in 1988. HB 2335 created a Children's Behavioral Health Council (CBHC) charged with making recommendations and overseeing the development of the continuum of services through 1993. HB 2338 designated Arizona Department of Health Services as the lead agency in planning, developing and implementing the comprehensive continuum of behavioral health services for children and includes a centralized screening and intake process which also provides on-going case management services. HB 2338 requires all state agencies serving children with behavioral health problems to enter intergovernmental agreements to develop a coordinated system of care.

GEORGIA

Georgia CASSP sponsored eight regional one day Families as Allies workshops between November and June. All workshops had legislative participants and most had media coverage. CASSP is working with key parents, identified through these workshops, to develop a statewide parent network. The legislature has also appropriated funds to a seven county area to increase Outpatient Service capacity, Day Treatment service slots, and Respite Care, and to develop Therapeutic Foster Care and In-home Crisis Services.

HAWAII

Under the Governor's reorganization of the Department of Health, a Child and Adolescent Mental Health Division has been created, effective July 1, 1989. This brings children's services to an equal organizational level with adult services for the first time. The legislature has approved expanding the system of care for Hawaii's children by funding eight adolescent day treatment programs, a staff-secure adolescent crisis evaluation unit, five positions for local system managers for the Hawaii Cluster System and flexible funds to be utilized by regional children's services units to prevent hospitalization.

IDAHO

Marilyn Sword of the Idaho CASSP staff chaired a statewide Parent Task Force meeting to begin designing a Parent Information Packet for the parents of any child placed in an Intensive Treatment Facility statewide. In September, CASSP will co-sponsor a collaborative, statewide conference with the Mental Health Advisory Council, the Community Mental Health Centers and the Division of Family and Children's Services.

As of July 1, 1989, Idaho CASSP split funds a "Child Mental Health Coordinator" position with the Division of Family and Children's Services (FACS). Funding for the position will be assumed entirely by the Family and Children's Services Division as CASSP phases out. This position will represent the first such child mental health position ever established within the Idaho Department of Health and Welfare and will provide post-CASSP child mental health programming expertise to the newly-formed FACS Division.

IOWA

The Iowa General Assembly has increased the funding for a family support subsidy. Families with children with mental health or retardation problems that are headed to institutionalization can receive a family support subsidy to prevent a residential placement for the child. In fiscal year 88-89, $75,000 was budgeted and 54 families were served. For fiscal year 89-90, $400,000 is available in payments of $245.34 a month to families with incomes less than $40,000 a year.

KENTUCKY

Kentucky's Department for Mental Health and Mental Retardation Services (DMHMRS) recently hired a parent consultant to help parents find available resources and to establish parent support groups across the commonwealth. Recently, Kentucky's DMHMRS hosted its first Mental Health Institute on the campus of Eastern Kentucky University. This event provided 500 professionals with intensive training on community-based services for children with serious emotional problems, families experiencing domestic violence and adults with severe mental illness.

MAINE

Maine's CASSP project has graduated and federal funding of the program is being exchanged for state funding. A recent session of the Maine legislature appropriated funds for CASSP project positions as part of the state's Bureau of Children with Special Needs. New funds have been appropriated for case management/mediation, family support and intensive residential services. The state legislature also completed Maine's Children's Rights Regulations. The regulations are now being implemented for recipients of services from the Bureau of Children with Speical Needs. This summer, Dr. David Born of the University of Kansas has been helping Maine develop outcome indicators for children's mental health contracts.

MARYLAND

The recently created Governor's Office for Families, Children, and Youth is reviewing the entire youth service system to consolidate and improve coordination of all youth services from early intervention to long term institutional care. In addition, $3.2 million is available this year to enhance new community-based mental health services for children and youth, continuing an expansion process begun in 1988 which will total approximately $9 million over three years. The state has undertaken a significant systems reform process in partnership with the Casey Foundation which emphasizes family preservation, interagency planning and budgeting, and the local development of a single, non-categorical point of entry. Maryland CASSP is working closely in coordination with all

of these initiatives and is concentrating efforts on the return of SED youth from out-of-state placement and the continued growth, expansion, and empowerment of the Parent Assistance Network.

MASSACHUSETTS

Massachusetts has entered into formal Interagency Agreements with the Department of Social Services (DSS) and the Department of Youth Services (DYS) regarding crisis intervention, screening and psychiatric hospitalization for all clients in the care or custody of these agencies. Any child or adolescent in the care or custody of DSS or DYS may only access psychiatric hospitalization through the Department of Mental Health, which functions as the gate keeper.

Administrators from each of the agencies involved are developing joint plans to meet the crisis intervention needs of children and adolescents who do not require hospitalization. A unique Interagency Agreement, spearheaded by the Executive Office of Human Services and signed by all of the State human service agencies that serve children, has been developed to address the special needs of the juvenile sex offender population. The agreement includes assessment, treatment on an inpatient and outpatient basis, and staff training. Massachusetts has, for the first time in its history, imposed a cap on the number of child and adolescent psychiatric inpatient beds and on the census of public sector inpatient services. This new policy has resulted in fewer admissions and higher quality inpatient care.

MINNESOTA

The Minnesota state legislature has approved a mental health plan incorporating the CASSP model and mandating a comprehensive set of services for children's mental health. By mid-year 1991 each county is to have an early identification and intervention program, case management services, family community support services, day treatment services, professional home-based family treatment, and therapeutic foster care.

MONTANA

The Mental Health Bureau of the Montana Department of Institutions has recently requested proposals on the implementation of a new mental health/special education joint services program for emotionally disturbed children. Through interagency agreements, community mental health centers and local school districts will collaborate to serve children and adolescents identified as emotionally disturbed by school personnel. The state's mental health planning process has idenified interagency collaboration on the local level as the most important issue pertaining to mental health services for children and youth in Montana.

NEW HAMPSHIRE

New Hampshire's CASSP project has set up advisory and management planning committees involving staff members from several state agencies, other allied providers and advocates. Systematic interagency collaboration between the Division of Mental Health and Developmental Services and the Division of Children and Youth Services has begun around case reviews in order to attend to children with the most pressing problems.

Legislatively, effective July 1, 1989, New Hampshire has expanded Medicaid coverage for certain children with severe disabilities who live at home. This expanded coverage is known as the "Katie Beckett" option and will allow certain eligible children to receive Medicaid covered services.

NEW YORK

Twenty-one family support service programs modeled after the CASSP-funded family groups will soon be operating throughout New York State due to a $1 million state appropriation. Respite, family support groups, family recreation, and parent advocacy training are to be provided. Thirteen goups were funded during 1989. For a group facilitators manual, write to the New York CASSP Coordinator. Also available is a parent-professional training manual. The New York Office of Mental Health and the Edna McConnell Clark Foundation will be jointly funding several programs targeted at formerly homeless families and children.

New legislation being introduced this year would create a New York State Family Policy including a set of guiding principles against which all state agency programs serving families and children would be measured.

OHIO

The Ohio Department of Mental Health (ODMH), Bureau of Children's Services, recently provided Cultural Awareness/Sensitivity Training to nine selected mental health board areas.

Participants received a comprehensive training guide from ODMH that provided a substantial amount of information on various cultural and ethnic groups in Ohio. Each board area received intensive training that included skill building practices, learning by doing exercises, expanding agency and individual cultural competency, and other related topics.

OKLAHOMA

OCASSP is seeking to restructure the funding mechanisms used to pay for mental health services to allow for the reimbursement of programs which are more tailored to a child or adolescent's specific mental health need. A coalition of representatives from the public and private sector has been created to look at Oklahoma's current system of care and to recommend changes. By providing technical assistance and education to insurance carriers, business coalitions, and service providers on the benefits and cost-effectiveness of home and community-based services, OCASSP and others involved hope to change the way mental health services for children are conceptualized and subsequently funded in Oklahoma.

CROSS COUNTRY UPDATE

RHODE ISLAND

The New England Children's Mental Health Task Force is celebrating its 20th anniversary. The task force encourages an exchange of ideas from education, child welfare, mental health and parent support group networks. The task force has three functions -- advocacy, education and information sharing on children's mental health issues. Since 1970, the group has written booklets on services, created two award-winning films on parenting, held a national conference on disturbed youth, developed economical workshops and has overseen the New England Head Start program.

TENNESSEE

Parents of children with severe emotional problems testified for the first time on their children's needs before the Commissioner's Task Force on Children's Mental Health. A CASSP minority consultant has been hired to coordinate the state's efforts to serve black children and youth with severe emotional problems and their families. The state is negotiating with the Bureau of Medicaid to be reimbursed for community based services. More than 200 children's mental health professionals, advocates and parents attended a CASSP and Children and Adolescent Services sponsored statewide conference. A demonstration project called Assessment, Intake and Management System is to eliminate departmental custody of children and turn custody over to the state. An interagency team will assess each child and direct services. The Tennessee Department of Mental Health and Mental Retardation and The Tennessee Department of Human Services have begun a Home Based Demonstration project with six pilot programs to help build a central intake system for all youth entering state custody or in need of out-of-home care. A federal DHHS, OHDS grant of $150,000 has been granted for a respite program for families of SED, autistic or dual-diagnosed emotionally disturbed and mentally retarded children.

STATE CONTACTS:

Martha P. Bruce
CASSP Project Director
Department of Health
Division of MH/A&DDS
6 & 7 Estate Diamond Ruby
Christianstead, St. Croix
U.S. Virgin Island 00820
(809) 773-1992

Ron Caldarone
Assistant Director
Dept. of Children & Families
Div. of Child's MH Services
610 Mt. Pleasant Avenue
Providence, RI 02908
(401) 457-4701

Miryam J. Choca
Executive Director
Children's Behavioral Health Council
Department of Health Services
411 North 24th Street
Phoenix, AZ 85008

Caren Craine
CASSP Director
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Duane Doidge
Dept. of MH/MR
Doctor's Building
706 Church Street
Nashville, TN 37219-5393

Stormie Ellis
CASSP Project Director
Dept. of Health & Human Services
Div. of MH & Developmental Svcs
105 Pleasant Street
State Office Park South
Concord, NH 03301
(603) 271-5000

Travis Gameson
Dir. of Demonstration Projects
Dept. of Mental Health
1200 NE 13th Street
Oklahoma City, OK 73152-3277
(405) 271-7474

James Harrod
CASSP Coordinator
Dept of MH/MR
State House Station #40
Augusta, ME 04333
(207) 289-4251

Elnora L. Jenkins
Cluster Consultant
Bureau of Children's Services
Dept. of Mental Health
30 East Broad Street
Columbus, OH 43215

Mike Kauffman
Quality Assurance Manager
Mental Health Bureau
Dept. of Institutions
1539 11th Avenue
Helena, MT 59620-1301
(406) 444-3930

Jody Lubrecht
CASSP Director
Dept. of Health & Welfare
Div. of Family & Child Services
450 West State Street, 10th Fl.
Boise, ID 83720
(208) 334-5520

Gerald F. McKimmey
CASSP Program Director
Dept. of MH/MR
Central Office
P.O. Box 12668
Austin, TX 78711-2668

Tom Merrick
CASSP Project Director
Mental Hygiene Administration
201 W. Preston Street
Baltimore, MD 21201
(301) 225-6649

Dawne M. Mickle
CASSP Project Director
Division of MH/MR/SA
878 Peachtree Street, NE
Atlanta, GA 30309-3999
(404) 894-6300

Joan Mikula
Assistant Commissioner
Child/Adolescent Services
Dept. of Mental Health
160 North Washington Street
Boston, MA 02114

Dennis G. Olson
Child/Adolescent Mental Health
Dept. of Social and Health Services
Mental Health Division
Olympia, WA 98504-0095
(206) 586-3007

William A. Quigley
Acting Chief
Child/Adolescent MH Div
3627 Kilauea Ave., Rm. 101
Honolulu, HI 96816

Sherry Schoenberg
CASSP Coordinator
Dept. of Mental Health
103 South Main Street
Waterbury, VT 05676
(802) 241-2609

Bill Scott
CASSP Director
Dept for MH/MR Services
Commonwealth of Kentucky
Frankfort, KY 40621

Joan Sykora
Program Consultant
Child/Adolescent Services
Dept. of Human Services
444 Lafayette Road
St. Paul, MN 55155-3828

Sue Tipton
Division of MH/MR/DD
Dept. of Human Services
Hoover State Office Bldg.
Des Moines, IA 50319
(515) 281-4632

BEST COPY AVAILABLE

TEXAS

For the first time in Texas history, the state legislature has appropriated $2 million to provide services to children with severe emotional disturbances. Combined with Medicaid expansion to provide reimbursement, this funding creates new opportunities for the CASSP population statewide. CASSP will be active in developing training modules for case management and in-home services, as well as facilitating interagency coordination groups. Other CASSP projects include expansion of parent support/advocacy groups, and enhancement of the client information system to include CASSP-related data.

VERMONT

Vermont CASSP has moved ahead in efforts to implement the System of Care Plan for severely emotionally disturbed children and adolescents and their families. Highlights in program development include the statewide implementation of Respite Care and the Community Integration Demonstration Project.

The Vermont Respite Care Demonstration Project is developing under a federal grant. One parent and respite care coordinator from each community mental health center have been trained and are responsible for identifying respite families, hiring respite workers, offering training and participating in ongoing program evaluation.

The Community Integration Demonstration Project is a small pilot program focused on bringing children back from intensive out-of-state placements through coordinated case management and individualized service planning.

VIRGIN ISLANDS

Virgin Islands parents attended the March 1989, CASSP Project Director's meeting. This year, a parent and current CASSP Board member will be officially serving as liaison for all CASSP/Parent activities, the first of which will be a parent survey to assess and assist with current parent needs for information and training.

WASHINGTON

Washington state has begun a $1 million initiative to help local communities develop the capacity to care for their most difficult-to-serve seriously emotionally distrubed children. Tied to a mandatory service called community support, seven sites received funding for three year projects to provide "individualized wrap-around" service to children with few options and most likely to be removed from the community in order to receive care. Three of the seven sites focus on minority populations. Key features of this initiative consistent across all sites include: 1) Interagency gatekeeping mechanism consisting of high level administrators from all the publicly funded systems legally responsible to serve children. 2) Once admitted, a treatment team consisting of all key people in that child's life is established and meets as needed to develop, implement and reconfigure an individualized wrap-around program. 3) Intensive ongoing consultation and technical assistance is available from national and local experts as well as networking among the seven sites.

Report Focuses on Out-of-State Placements

The National Mental Health Association (NMHA) released its report on the "Invisible Children" project at a press conference in Washington D.C. on June 6, 1989.

The two-year, national study tracked the residential placement of children with emotional disturbances and found states tend to over-use out-of-home treatment placements, according to Chris A. Zeigler-Dendy, report consultant. The report also found many of the children could have been served as effectively in their own community, if appropriate community services had been available.

The study coined the phrase "Invisible Children" to describe children and adolescents who are not receiving proper treatment.

Anne Ince, chairman of the NMHA Children's Committee, used a quote from colleague Dr. Robin Kirk to summarize the situation at the press conference. "Children and families have access to either outpatient counseling or inpatient hospitalization, a situation analogous to a patient with heart disease having access to only an aspirin, or a transplant," Ince said.

Ince urged the creation of a community-based, family focused system of care for children with emotional disturbances. "We are spending well over a billion dollars to serve about 26,000 children in state hospitals and out-of-state care. And, what are we getting for our money?" Ince asked.

The study found there is a lack of information regarding children with emotional disturbances including their numbers, their diagnoses, their treatment costs and their whereabouts. The study also found a lack of communication and gatekeeping between the various agencies that place these children including child welfare, juvenile justice, education and mental health.

The study recommends treatment should be offered in a less restrictive setting before placement in a hospital or residential facility is considered. Dendy said these children need intensive treatment but intensive treatment is not synonymous with residential care.

Some states have initiated changes to improve the situation since the "Invisible Children" project first began. In most states more funding is needed to establish a community-based system of care, Dendy wrote.

For a copy of the full report and recommendations, write the Executive Office, The National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971.

PROGRAM UPDATE

Interagency Collaboration

By Jane Knitzer and Susan Yelton

This article was an outgrowth of projects supported by the Edna McConnell Clark Foundation.

During the last few years, calls for collaboration between public child mental health systems and child welfare systems have been increasing. These public systems, confronted with the many complex needs of the children, strapped by the high cost of placements, limited by inadequately trained staff with unmanageably high caseloads, and, to some degree, pressured by legal mandates, are actively searching for new solutions and new approaches to these tough issues.

In addition, recent evidence being gathered by states is suggesting that many of the families coming into the child welfare system have more emotional problems than in years past and child mental health caseloads are looking more like child welfare caseloads. For example, in August 1987 the Washington State Children's Interagency Committee developed a plan for the 31 emotionally disturbed children in out-of-state placements. They reported that 80 percent were victims of abuse and neglect and 60 percent had more than five out-of-home placements. New York State's Family Based Treatment Program, 1989 annual report indicates that the majority of the children placed with professional parents are in the custody of the Department of Social Services (DSS). The report suggests that to serve the most disturbed youth in DSS custody in a Family Based Treatment home is not a duplication of effort, but the creation of an alternative currently lacking for these youth in the system as a whole. Issues such as these have led to a new receptivity to cross system collaborations, particularly those involving public child welfare and child mental health agencies.

Service Delivery Initiatives - Family Preservation

From a program perspective, perhaps the most important development in the service delivery system is the growth of short term crisis interventions, often known as "family preservation services" (Edna McConnell Clark Foundation, 1985). These interventions are defined by characteristics that, taken together, mark a paradigm shift in thinking about working with families. They are home based; they are time limited, typically, four to six weeks in the shorter ones and up to three months in the longer ones; they are intensive, with between five and twenty hours of direct, face-to-face contact and the workers have small caseloads, between two and five families per week.

Today the notion of in-home therapy has gained considerable credibility, and intensive in-home programs are springing up all over the country. The Homebuilders program in particular has become the model for many of these. Now run under the auspices of the Behavioral Sciences Institute, it has grown enormously; its direct services reach into six counties in the State of Washington and into a recently established program in New York City, while its training staff has spread around the country offering technical assistance to countless programs and public officials (Kinney et al., 1988).

From a system perspective, what is most significant is that family preservation services have served as a catalyst for child welfare-mental health collaboration at both the program and policy levels. Most notably, the service has fostered the development of cross-system referral procedures, community-based interagency planning teams and joint funding of programs. For example, programs carried out under mental health auspices, such as those run by community mental health centers, accept

"These interventions are defined by characteristics that, taken together, mark a paradigm shift in thinking about working with families."

referrals from child welfare. In fact, abuse and neglect referrals from child protective services sometimes constitute the major eligibility category. Going one step beyond referral, a smaller number of programs rely on an interagency group to screen referrals to determine who gets into the program. In Kentuck and Louisiana, the family preservation programs supported b mental health have incorporated this approach.

In Berkely County, South Carolina, the family preservation program operates through the local community mental health center serving a rural but fast growing community. Reaching into the community, the program has established a multi-agenc board, including the sheriff, the director of special education and representatives from youth serving and substance abuse programs to help select cases, navigate follow-up services for the clients and garner community support.

Equally exciting is a new initiative beginning in Contra Costa, California. There, four public systems that place children -- child welfare, probation, mental health and special education -- have come together to form a steering committee to plan and implement a family preservation program that will accept children from all four referral sources. It has been Maine's experience that mandating the creation of multi-agenc interdisciplinary steering committees, consisting of representatives of child serving agencies within the area served by a famil preservation program and appropriate representatives of education, human services, mental health, and corrections, is essential to effective program operation.

Fiscal cost sharing is perhaps one of the most obvious and most central (and most difficult to bring about) routes to cross-system collaboration. In Kentucky, for example, collaborative state planning has resulted in child welfare funds being made available to several community mental health centers for the

development of a range of home-based programs delivered through community mental health centers and modeled, to greater or lesser extent, on the Homebuilders program, some in rural areas, some in urban. In North Carolina, efforts are underway to supplement the existing network of family preservation programs funded and delivered through mental health agencies that serve child welfare clients with new programs that are collaboratively funded. Virginia's State Interagency Consortium on Services for Seriously Emotionally Disturbed Children funded six interagency family preservation programs for fiscal year 1989-90 as well as other interagency service projects.

Given the interest in family preservation from multiple systems, and especially child welfare and mental health, it is virtually inevitable that states will have to rationalize, across systems, the geographic distribution, the systems for monitoring and training, the approaches to the legislature, differences in program design and a host of other aspects that are involved as states make a deeper commitment to family preservation services. Without careful planning we can expect controversy about model design and contracting procedures, concern at the local level about recruitment efforts, salary differentials and potential oversaturation in one community while other communities have nothing.

It should also be noted that as a reflection of the interest among states in cross system collaborations, during 1988 two-thirds of the states participated in Edna McConnell Clark Foundation supported meetings to which representatives of both mental health and child welfare were invited in order for both to learn about family preservation as an intervention strategy and to explore the potential for cross-system collaborations. In some states, these meetings have stimulated further cross-system dialogue, and sometimes, more small changes. For example, state administrators in Wisconsin jointly planned and sponsored a replication of the national conferences which resulted in cross-system planning at the county level. In Massachusetts, regional child welfare and mental health administrators met to discuss alternatives to hospitalization. This was the first time Massachusetts held a meeting for regional administrators from both child welfare and mental health agencies. In Nevada an increase in Title IVE funding resulted in the state's first family preservation program. It is operated by mental health and targets families referred by child protection staff.

"Experience to date suggests that there are three critical ingredients to a successful collaboration: leadership, a set of shared goals, and a realistic sense of time."

Other Points of Collaboration

Many of the collaborative program ventures around the country have centered around family preservation services, however there are scattered attempts to work collaboratively at other pressure points between child welfare and mental health systems, long identified as problematic. There are also long-identified pressure points that remain, as yet, in search of substantive models.

Ensuring appropriate placements: Both at the state and local levels, cross-system efforts have developed around the placement process itself. At the local level, a number of communities have mobilized cross-system/cross-discipline committees, sometimes including advocates and parents, sometimes only providers, to decide collectively whether a child needs residential placement. Sometimes these interagency placement committees are targeted to all children at risk of placement, other times only the tougher cases. Increasingly, with experience, they are evolving into broader roles, including helping to package community-based services, and sometimes orchestrating the use of case managers as well. Florida has been using its network of case review committees for several years and, in a number of communities, it seems to have had an impact. Vermont, too, with leadership initially from the state level CASSP office, has set up a network of interagency committees throughout the state. In Ohio, since 1984, there, multi-agency clusters, both at the state and local levels, focus on trying collectively to meet the needs of the most difficult to serve, multi-need children and families.

Preventing Disrupted Adoptions: A pressing issue in child welfare, with clear mental health implications, is that as we become more successful at the adoption of children already seriously damaged by early trauma, including sexual abuse, we need to work harder to prevent the failure of these adoptions once they have been finalized.

A number of states are beginning to try to plan preventively to forestall what has become known as disrupted adoptions. Both Kentucky and North Carolina, for example, have recently mounted such efforts. As a result of statewide cross system training on adoption issues, both states report much success in sensitizing mental health personnel to the issues surrounding the adoption of children with special needs.

Returning Children from Out-of State Placement: In 1978 when the Children's Defense Fund released its examination of the child welfare system, one of the findings concerned the heavy reliance on out-of-state placements. In 1988, the National Mental Health Association re-examined the issue of children in out-of-state placement and once again, the patterns are sobering.

The problem is so visible and so troubling that in a number of states, the data have propelled a new look at alternatives. One of the most comprehensive and collaborative of these has

been the Alaska Youth Initiative, spearheaded by the Alaska CASSP program. There, the CASSP agency has joined with the education agency and the Division of Family and Youth Services. Together, they have both pooled monies and developed careful individualized plans for the return of Alaskan children, many of them Native Americans, placed in other states. What is particularly interesting about the effort is that in creating support systems for these children in their own communities, the AYI has turned to the Native American communities themselves. It has both paid and trained parents, family members and the like to respond to and cope with specialized needs. States such as Washington, Montana and Wyoming are seeking to replicate the Alaska model.

One program model that has developed specifically to address the need for alternatives to restrictive residential placements is therapeutic foster care. This is a highly specialized model that often involves child welfare and child mental health collaboration (see UPDATE, Volume 2, Number 1, for more discussion of this model).

Comprehensive Systems Change

The efforts just highlighted focus on particular aspects of the placement prevention and placement processes. But the most potentially significant developments in re-thinking approaches to troubled children and adolescents lies in more comprehensive, holistic efforts to re-orient the service delivery system in three ways simultaneously: (1) strengthening, systematically, the range of non-residential services that are available to children and families across systems, (2) anchoring responsibility for individual children through a cross-agency case management system and (3) creating a new organizational framework to facilitate cross-system decision-making and resource sharing.

These more comprehensive and ambitious efforts have centered on better meeting the needs of the most seriously troubled children and adolescents -- those at risk of highest cost out-of-home placement. To a large extent, these have emerged out of the CASSP program itself or the thinking that undergirds it. Ventura County, California, is the home for perhaps the most well-developed experiment in cross-system collaboration. The Ventura County project provides for four systems-child welfare, juvenile justice, education and mental health - to develop and operate collaborative programs which address the needs of children who are at risk of out-of-home placement.

Other parts of the country have also demonstrated the capacity to create new frameworks to facilitate cross-system change. Examples are the Ohio Cluster Program, Florida Multiagency program for severely emotionally disturbed students, the Virginia state-level interagency initiative and the Pennsylvania county-based CASSP program. And we have to be encouraged by the initial response to the Robert Wood Johnson Foundation Children's Mental Health Project.

Necessary Conditions for Successful Collaboration

The goal of cross-system collaboration is an admirable one. But the truth is that talk about coordination of services is not new. The rhetoric of cooperation and interagency coordination has long been a part of service delivery jargon. The reality of such cooperation and coordination, however, is quite a different matter. What takes the current interest in collaboration one step beyond the stock-in-trade rhetoric of interagency cooperation is the emerging consensus about the importance of avoiding unnecessary placements coupled with the tangible evidence that new approaches, such as family preservation services or multisystem collaborations or systems-of-care, seems to work. This defines the paradigm shift that makes it possible to move toward a new vision of services.

Experience to date suggests that there are three critical ingredients to a successful collaboration: leadership, a set of shared goals, and a realistic sense of time. Strong leadership is, of course, the most elusive. Somebody must, either by mandate or by predilection, want collaboration to happen and must have enough clout to draw in the other actors.

Equally important, however, is a set of shared goals. The growing support from both child welfare and mental health agencies for the policy driven goal of preventing unnecessary placement thus represents a boom for collaborative efforts. It defines a tangible outcome, even as service providers are creating new program models, such as family preservation services, that provide the means to achieve the outcome. While this does not guarantee the end of turf battles, it does provide a focus that hitherto has not been as clear nor as widely articulated.

The third component, the need for time, cannot be underestimated. States, communities and individuals charged with responsibility for troubled children develop their own histories and ways of functioning. Changing these can be as complex a process as trying to change a family's functioning. There is no one magic recipe. What is critical is starting the process; providing a context that will nurture and encourage goal-oriented cross-system collaborations.

A successful collaboration is somewhat akin to a successful cross-cultural endeavor. Different systems have different strengths, different weaknesses, different fiscal resources and different mandates. These must be openly explored at all levels.

In summary, the incontrovertible fact is that if we are to provide more responsive services to troubled and at-risk children and families, if we are to do better at keeping them in stable living situations, and wrapping the services they need around them, mental health and child welfare need each other. The time is ripe. The program models continue to emerge. The policy challenge is to restructure the fiscal and organizational web that has been created to support these new models.

For references on Interagency Collaboration see page 23.

Replication of Model Programs Underway

Past issues of UPDATE have described significant system of care developments in several states. This issue briefly describes efforts to replicate the Ventura, California model in three other California counties, to transport the Alaska Youth Initiative model to other states, and to expand the system of care in North Carolina to children who are military dependents in the Ft. Bragg area.

California

California has allocated $1.4 million dollars per year for a replication of the Children's Demonstration Project of Ventura County in three counties, according to Betsy Burke, Director of the Special Populations Branch in the California Department of Mental Health.

The Ventura project was started in July, 1985 to develop a cost-effective intergency network of coordinated services for children with serious emotional disturbances who had been removed from their home, or were at risk of being removed. Under the leadership of Randall Feltman, the project brought together services provided by mental health, child welfare, juvenile justice, and education.

In 1987 the California Legislature passed a law paving the way to expand the project to other counties. Proposals were received from 22 counties, and three were chosen, Santa Cruz, San Mateo, and Riverside, according to Burke. California is also funding an independent evaluation of the replication of the model.

Although the initial funding for the Ventura Project was $1.5 million per year, Burke emphasizes the replications are "not as costly as it was for Ventura because the new counties had already begun the process...they needed money to complete the process rather than to begin it."

The new counties have already started operations and performance contracts have been developed for these projects emphasizing specific client outcomes rather than units of service.

North Carolina

On September 1, 1989 a five year project to develop, implement, and evaluate a system of care for children and adolescents who are military dependents was initiated in Fayetteville, North Carolina near Fort Bragg, according to Lenore Behar, Special Assistant for Child and Family Services for the North Carolina Department of Human Resources.

According to Behar, the major objectives of this program, funded by a Department of Defense grant, are "to fully fund a continuum of care to demonstrate it's effectiveness in meeting the mental health needs of the children, and to impact on CHAMPUS and other third party payers by demonstrating that this is both effective and efficient."

Under CHAMPUS, the insurance program covering military dependents, mental health coverage for children was available for outpatient services, and services provided either in residential treatment centers or hospitals. The new program will provide a varied range of services, building on the prior system-building activities that have taken place in North Carolina.

An independent evaluation conducted through Vanderbilt University will include a comparison between children at Ft. Bragg and Ft. Stewart in Georgia and Ft. Campbell in Kentucky.

Behar hopes a successful evaluation will spread the project to other military installations and CHAMPUS in general.

Alaska

John VanDenBerg, Coordinator of Child and Adolescent Mental Health in Alaska, reports that the highly individualized multi-agency treatment approach utilized to serve children in Alaska is being used in states such as Montana, Washington, and Wyoming as well.

The Alaska Youth Initiative (AYI) was essentially a statewide application of individualized treatment approaches developed by the Kaleidoscope program in Illinois, VanDenBerg reports. AYI is a collaborative effort between mental health, child welfare, and education systems.

The AYI approach uses funds in a flexible manner to develop individualized treatment programs rather than place children in existing categorical programs. While AYI was originally geared to bring Alaska children back from out-of-state placements, it is now used to maintain children in their own home and community, and avoid placement altogether.

Washington state is the furthest along in using the AYI model to return children from out-of-state placements. In a one-year period ending March 1, 1989, Washington's program succeeded in returning 38 out of 43 target children. Monthly costs were redirected from $4,490 per month to $2,020 per month, and behaviors such as suicide attempts and destructive acts were reduced.

Washington state emphasizes the importance of interagency teams at the state and local level, core treatment teams including family and community staff, and a case manager, to implement such a program. Washington reports using flexible funding as a method to allow "specific, individualized and creative plans to be developed for extremely difficult youth."

VanDenBerg is pleased with the adaption of the AYI model, but emphasizes the need for a strong focus on quality control issues and for evaluation of treatment effectiveness over an extended time period.

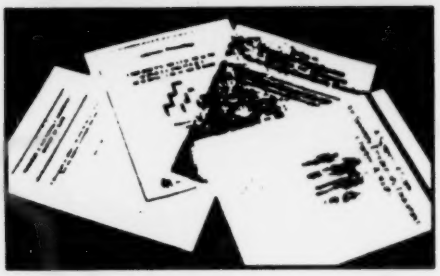
For information contact:

Betsy Burke, Director
Special Populations Branch
Dept. of Mental Health
1600 9th Street
Sacramento, CA 95814
(916) 323-9289

Lenore Behar, Special Assistant for Child and Family Services
Division of MH/MR/SAS
Dept. of Human Resources
325 N. Salisbury Street
Raleigh, NC 27611
(919) 733-0598

John VanDenBerg, Coordinator
Child & Adolescent Mental Health
Division of MH/DD
Dept. of Health & Social Services
Box H-04
Juneau, AK 99811
(907) 465-3370

Richard Westgard, CASSP Project Director
Dept. of Social & Health Services
Mental Health Division
Mailstop: OB-42F
Olympia, WA 98504
(206) 586-3775



1. Ira Lourie, Director of CASSP, at Project Director's meeting in October, 1988.

2. Monographs produced as part of the CASSP effort.

3. Diane Tucker and Susan Ignelzi, of Ohio, speak at "Mental Health and Education" conference held May, 1988 in Washington, D.C.

4. Participants at October, 1987 CASSP Project Director's meeting in Washington, D.C.

5. Barbara Friesen, Director of Portland State Research and Training Center.

6. John VanDenBerg, Alaska Coordinator for Child and Adolescent Mental Health.

7. Ellen Kagen, CASSP Coordinator at the Georgetown Child Development Center; Karl Dennis, Executive Director of Kaleidoscope-Chicago and Mareasa Isaacs, Administrator of Child/Youth Services Administration in Washington, D.C. at CASSP Training Institute in Boulder, Colorado, July, 1988.

8. Judith Katz-Leavy , CASSP Deputy Director and Beth Stroul, CASSP Consultant at CASSP Training Institute.

In the summer of 1984, the Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health (NIMH) awarded its first grants to ten states. Since then, NIMH has awarded CASSP grants to more than 40 states. As CASSP turns five years old, this special section of UPDATE was prepared to review its progress, and to identify areas in need of further growth and development.

This article presents views on the development of CASSP from individuals in the federal government, several states, and advocacy organizations. Included in this section is a chronology showing the progression of CASSP activities and funding.

Objectives of CASSP

CASSP -- an important step in the right direction but only one of many steps needed to raise mental health services for children and families to the level at which they should be. That is the consensus opinion of those interviewed by *UPDATE* for this article.

The original, basic goal of CASSP was to get a child mental health person in every state, according to Dr. Ira Lourie, director of CASSP for its duration. A more ambitious goal was to make "large scale changes in the way services are delivered."

The idea was to get states to pay more attention to the mental health needs of children, said Jim Stockdill, director of NIMH's Division of Education and Service System Liaison during CASSP's first five years. NIMH was seeking to address problems that had been identified by Dr. Jane Knitzer in her book "Unclaimed Children," published in 1982.

Knitzer studied services for children with emotional disturbances and their families and found that very few states had even a semblance of a system of care. Public agencies often refused to accept responsibility for serving these children and many state mental health offices lacked even a single full-time children's staff person.

Knitzer saw the establishment of CASSP as an effort "to strengthen leadership at a state level around children's mental health, redefining it as a mutli-agency challenge, and serving as a catalyst to develop a strong system within communities with a focus on non-residential care."

A strong partner of NIMH in the development of CASSP was the national organization of State Mental Health Representatives for Children and Youth (SMHRCY), according to Lourie and Stockdill. Martha Forbes, SMHRCY Chairperson at the time CASSP was initiated, recalls that it was her hope that CASSP would lead to an increase in "meaningful, responsive services" for children through increasing coordination of service, and developing a common language among different systems.

As CASSP progressed, its goals evolved, according to Lourie. An increased focus on redefining the role of parents and involving them more actively in the system developed, he said. There was also more of a focus on creating a system that was responsive to culturally diverse groups and developing strategies for serving homeless children.

Dr. Judith Meyers provides further perspective on the context in which CASSP was created in an article published in the Journal of Clinical Child Psychology in 1985. While the provison of mental health services is primarily the responsibility of states, she wrote, "the federal government, however, has a role in ensuring that states provide comprehensive and effective systems of care to all those who are in need." She also wrote that while this federal responsibility is recognized, "the history of federal involvement in mental health services for children is a story of failure marked by a series of initiatives that

CASSP - A Fifth Anniversary

have neither survived beyond a few years nor accomplished much of lasting significance."

Accomplishments of CASSP

It is against this background of inadequate children's mental health services in the states and short-lived prior federal efforts in children's mental health that the success and failures of CASSP must be considered.

On the basic goal of increasing attention to the needs of children and families, CASSP received strong reviews from the individuals interviewed by *UPDATE*.

"CASSP is an excellent national and state level effort to try to meet and adequately address the needs of seriously emotionally disturbed children and adolescents," said Kevin Concannon of Oregon, who was Commissioner of Mental Health in Maine at the time CASSP began. "CASSP funds are serving as a catalyst in a change of state systems specifically to better serve these underserved populations."

Marylee Allen of the Children's Defense Fund also refers to CASSP as an effective catalyst, particularly "in drawing attention to the problem, and getting various systems to work together."

The basic CASSP goal of getting a children's mental health person in every state has been just about met, reports NIMH's Lourie.

Barbara Huff, president of the new Federation of Families for Children's Mental Health, emphasizes the accomplishments of CASSP in strengthening the role of parents in developing better services for their children.

"The CASSP program has been fabulous overall," she said. "For families it has been the first thing they have had to latch onto, be involved in." Those who stress the success of CASSP in increasing family involvement include Knitzer, Lourie, Stockdill, and Paul VanderVelde of Michigan, current SMHRCY Chairperson.

Through the five years of CASSP there have been noticeable increases within the states in parental participation in meetings and on advisory boards, in the development of a range of parent support services, and in the overall re-examination of the role of parents. The "Families as Allies" project, developed by the Research and Training Center at Portland State University, has provided training to parents and professionals across the country, conducted regional conferences in each section of the country, and awarded grants to five states specifically for strengthening supports to parents.

CASSP has also had a positive impact in creating a vision of what a system of care for children with emotional disturbances and their families should look like, according to Judy Katz-Leavy, Assistant Chief of the Child and Family Support Branch of NIMH. She indicates that "CASSP has had tremendous success in disseminating the philosophy and the principals of a system of care."

The first national conference on a system of care, conducted in Colorado in 1986, and the monograph on a system of care, prepared jointly by the CASSP Technical Assistance Center at Georgetown University and the Research and Training Center for Children's Mental Health in Florida, has provided the model for this vision.

Vandervelde agrees that CASSP has been successful in "publicizing and making available to states information about successful models." In addition to a monograph on the overall model of a system of care, CASSP has resulted in monographs on home-based services and crisis services. An additional report on therapeutic foster care will soon be published. Program information has been included in issues of *UPDATE*, and presented at state and national conferences.

A significant monograph on services for minority children has also been published. This has helped create a vision of a "culturally competent system of care."

Future Agenda

Despite the consistent opinion that CASSP has increased the recognition of the need for improvement in children's mental health services, strengthened state-level leadership, presented and dis-

BEST COPY AVAILABLE

seminated a vision for a multi-agency system of care and increased the involvement of familes more than ever before, there are a number of items of unfinished business and a general concern about the future.

One major concern is the continuing need for improved services. According to Lourie, while there have been "many significant changes at both state and local levels, and there is a national movement towards better service delivery that has joined with a parent movement, changes are not yet deeply entrenched in any state or local jurisdiction...there is no place where it is truly complete or secure."

There is a need to "educate and motivate state legislators in every state in providing mental health services and supporting mental health systems," emphasizes Preston Garrison of the National Mental Health Association.

CASSP does not provide service dollars and there is a need for new dollars for service implementation, indicates Knitzer. Dr. Mareasa Isaacs, children's mental health director in Washington, D.C., also underscores that after planning is conducted there is just not enough service money available.

As a state-level administrator, Concannon agrees with the need for more service dollars. He indicates, however, that "money for services should come from state systems rather than from CASSP." VanderVelde also emphasizes that CASSP cannot be expected to remedy all of the problems, he calls for increased federal involvement in funding for prevention and early intervention treatment programs.

Overall, the call for increased money for services is a strong and consistent one but the specific form it takes is varied. It includes a focus on generating more money at state levels, developing additional sources of federal support, working through interagency mechanisms to create more resources, and modifying existing fiscal policies so that available money can be used more effectively.

Another frequently mentioned concern has to do with the future of CASSP as a program, and CASSP-type activities in general. Allen indicates, for example, that "keeping the momentum going is a challenge," and Isaacs asks, "Now that CASSP is not there in some states, will it continue?"

"More time is needed for consolidation of gains," said Lourie who further reports that the mechanism for that consolidation "is not yet clear and that is the next struggle." As part of that effort, Knitzer calls for passage of Congressional legislation maintaining CASSP rather than continuing to depend simply upon a line item in the budget. Forbes calls for more work on developing a formal national policy on mental health services for children.

The minority initiative is another major unfinished agenda item. As Lourie indicates, this was not an original priority of CASSP but has become a more critical one as CASSP has evolved.

"The minority initiative has only been a focus for two years. It is a very complex issue," Isaacs reports. "It seems like an add-on but, it needs to be ordinary business. As an add-on it doesn't really last."

The issue of training mental health professionals, particularly in university-based training programs, was also mentioned.

"The CASSP philosophy has got to get into the schools where they are training mental health professionals. Universities are not familiar with CASSP information," Issacs said. Katz-Leavy also emphasizes the need to work more with university faculty as well as with professional organizations. Ties with the private sector need to

1983-84

Congress budgeted $1.5 million for CASSP. 44 states applied for grants. 10 states received grants: Alabama, Alaska, Georgia, Hawaii, Kansas, Maine, Mississippi, New Jersey, Ohio and Wisconsin. CASSP Technical Assistance Center at Georgetown begins. Research and training center grants awarded to Florida Mental Health Institute and Portland State University jointly through Dept. of Education and NIMH funding.

$1.5 Million

1985

4 states added from 1984 budget: Indiana, Nebraska, Pennsylvania and Vermont. $3.9 million budgeted for 1985. 22 states applied for grants. 8 states added: Delaware, Idaho, Illinois, Kentucky, Louisiana, New York, Oklahoma and Tennessee, raising total grants to 22. All grantees required as part of their CASSP project to include as a goal increasing family involvement in service planning. First issue of *UPDATE* published.

$3.9 Million

1986

2 states added from 1985 budget: Washington and West Virginia. $4.7 million for new budget. 16 applications. 3 states and 2 local projects added: Iowa, Virgin Islands, Virginia, Brooklyn and Wichita, brining total to 27 states and 2 local projects. In January, 3-day workshop on "Mental Health Program Development for Minority Youth and Their Families" held in Atlanta. In April, first "Families as Allies" conference held for Western states. In July, national conference on systems of care held in Boulder, Colorado, and monograph on "A System of Care for Severely Emotionally Disturbed Children and Youth" published.

$4.7 Million

Chronolog

be strengthened and efforts to determine how the public and private sector can work in effective partnerships need to be made, said Katz-Leavy.

There is a need for an increased knowledge base on how to work effectively with these youngsters, Stockdill said. He indicates that "we need to study the efficacy of the newer treatment modalities in the system of care."

Summary

As CASSP completes its fifth year, there seems to be little doubt according to those interviewed that it entered a field in great need of assistance and has played a major role not only in assisting individual states but in creating a national movement. Some of the important accomplishments are in increasing state-level capacity to address the needs of children with emotional disturbances and their families, gaining greater recognition of these children's needs, establishing a vision of a system of care, increasing parental involvement and helping redefine the role of parents, and disseminating information on approaches to improving services.

Yet as long as the list of accomplishments is, so is the list of tasks yet to be completed. This includes translating the gains made so far into increased services, strengthening the effort to make the system of care culturally comptent, working more closely with universities and with the private sector, and building a stronger research base for system development.

CASSP is at a crossroads, say several of those interviewed. While significant gains have been made, and there is important momentum for further progress, the gains that have been made are not yet solidly entrenched and the momentum can easily swing in another direction. The efforts of the next few years will be critical in determining if CASSP is another short-lived federal initiative, or if a strong and articulate constituency will insure that the current gains will be maintained and the unfinished business completed.

B. Friedman and A. Algarin

1987

7 grants for local programs awarded to Alaska, Georgia, Kentucky, Louisiana, Massachusetts, Oklahoma and South Carolina, and a grant awarded to District of Columbia. Two projects in South Dakota and Massachusetts jointly funded with Administration for Children, Youth, and Families, raising total number of grants to 39. CASSP program review meeting held in Coolfont, West Virginia in August. New pre-CASSP state-level capacity building grants established. 4 additional "Families as Allies" conferences held in Midwest, Great Lakes, South, and Northeast areas. All grantees required to add to their CASSP goals a focus on improving services for minority youngsters and their families. Child and Family Support Branch formed within Division of Education and Service System Liaison of NIMH.

$5.6 Million

1988

$7.4 million new budget. Capacity building grants awarded to Arkansas, New Hampshire and Utah, states grants to California, Maryland, Missouri, North Carolina, Oregon, South Dakota and Texas, & local grants to Mississippi and Pennsylvania. Total grants now 50. Minority Resource Committee established. First national research conference on mental health services and policy for children held in Tampa in February. Conference on collaboration between mental health and education held in Washington in May. Training institutes held in Boulder in July on "Community-Based Services for Severely Emotionally Disturbed Children and Youth." Workshop on Medicaid financing held in Washington in September. Training for parent-professional teams held in Portland and family networking grants given to Hawaii, Montana, Minnesota, Virginia and Wisconsin. "Next Steps" working conference for parents of children with serious emotional disturbances held in Washington in December.

$7.4 Million

1989

$9.8 million budget. Final decisions on new CASSP grants not available at press time. Possibility that almost every state will have a grant by end of this cycle. Original 10 states complete five year grant cycle. Increased focus on evaluation with evaluation supplements available through grant application process. Second national research conference on services research for children held in Tampa in February, and Proceedings from first conference pubished. Monograph on developing a culturally competent system of care published, and monograph on financing of services published. After competitive process, CASSP Technical Assistance Center at Georgetown funded for five more years, and Research and Training Centers in Florida and Oregon each funded for five more years CASSP completes five years of operation.

$9.8 Million

# of CASSP

ANALYSIS

Researching the Research Needs

The Institute of Medicine (IOM), and particularly its Committee for the Study of Research on Child and Adolescent Mental Disorders have done a great service through their report on the need to establish a strong child mental health research program. There is much to be encouraged about both in the recommendations of the Committee, and in the actions of the National Institute of Mental Health (NIMH) to use the report as a basis for developing a National Plan for Research on Child and Adolescent Disorders.

The IOM report contains far too much information to be adequately analyzed in a brief article. This article is intended to briefly summarize some of the special strengths of the report as well as to identify areas of concern. The analysis will focus primarily on the implications of the report for the development of a sound empirical base for establishing effective systems of care for children with emotional disorders and their families.

Training and Support of Researchers

The IOM describes its recommendations as "capacity-building" in nature. The focus is not simply on the substantive areas within the child mental health field in which more research is needed but also on the capacity of the scientific community to conduct sound and relevant research, and the capacity of NIMH to provide strong leadership in this effort. There is a great need to strengthen research training and support of beginning researchers, and the report does an excellent job of calling attention to these needs. Unless these areas are attended to, increases in funding for actually conducting research will produce disappointing results.

As the IOM report indicates, "No field has a greater or more pressing need to recruit and support researchers than child and adolescent mental health, yet research in this area has almost always lacked the support it deserves and requires, both in professional schools and universities where most research is conducted, and among the private, local, state, and federal agencies that fund research."

It is also noteworthy that the report emphasizes the need for a multidisciplinary focus in child mental health research. Given the complexity of the problems to be addressed, the development of multidisciplinary teams is becoming absolutely essential. The report does an excellent job highlighting the need for the "core disciplines for child and adolescent mental health research" to be supplemented both by professionals from the basic sciences and the social and behavioral sciences. Clearly, from a perspective of system of care research there is a pressing need to involve more economists, sociologists, epidemiologists, and educators.

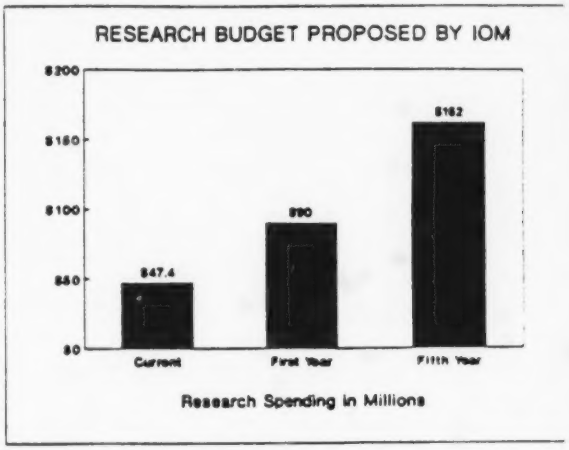
The report also indicates that "A major effort is needed to recruit more researchers from minority groups." There is not only an important need for this, but also to insure that the training of all researchers includes a thorough preparation to effectively deal with special issues in research with culturally diverse groups.

Similarly, within research training programs there is a need to provide training on broad service system and policy issues. This can play an important role in generating interest in young researchers in conducting mental health services and system of care research. At a more basic level, however, it can increase the relevance of research that is conducted, and heighten the likelihood that the ultimate goal of the research will be realized--the translation of the findings into improved services for children and their families.

As the role of families and consumers change in the mental health field, new and exciting research opportunities are created. It becomes essential, as well, that the perspective of family members and consumers be considered in the design of research and the training of researchers.

Focus of Research

The IOM report has well-recognized the need for expanded research in various areas. The recommendations call for large increases in research in epidemiology; assessment, diagnosis and treatment; prevention and special populations; services and systems of care; basic behavioral and social sciences; and basic neuroscience.



The report calls for an increase from the current annual level of research support of $47.4 million to a level of $162 million in five years. This is an exciting request which merits the strong support of child mental health advocates.

The reports indicates that, "Three elements appear to be fundamental underpinnings for research progress in this field. First, effective research must be motivated by a sophisticated appreciation of the developmental perspective...Second, comprehensive but fundamental understanding of the causes and determinants of mental disorders of children requires a multidisciplinary approach...Third, developmental studies demand longitudinal analyses." There is no question that an application of these "fundamental underpinnings" would be a major step forward for research in child mental health.

Specifically, in the area of research on service delivery and systems of care the report calls for an increase from the present level of $1 million to a level of $10 million in five years. The term "research on service delivery and systems of care" is significant in and of itself. On the one hand it recognizes the progress that has been made in focusing on the need for systems of care in order to adequately serve children with the most serious emo-

tional disorders and their families.

More important, however, it provides a focus for mental health services research that has been lacking. As indicated by numerous presenters at our Center's annual research conferences the last two years, as mental health policy efforts increase their emphasis on the need for community-based systems of care, there is a need for a shift in the research paradigm within mental health services research to take this into account. There is a need for research that will focus not just on comparisons between individual programs, or small nuances in the delivery of services, but will broach the broad issues of measuring and describing systems of care, evaluating their effectiveness, and assessing the effects upon systems of care of a range of organizational and financing variables.

Such research is complex, clearly requires multidisciplinary teams, and is expensive. The recommended budget for this type of research in the IOM report is in fact modest, given the expense of such research.

There are several research policy issues regarding system of care research that are only addressed in a cursory way in the IOM report, and that should be expanded upon as NIMH develops its national plan. These include approaches to involving multiple systems in supporting research much as systems of care aim to involve multiple systems in supporting services, mechanisms for integrating clinical and services research, procedures for increasing communication between researchers and policy-makers, and mechanisms for stimulating increased state support for systems of care research.

The IOM report understandably has its primary focus on the diagnosable mental disorder as the unit of study. Within this framework, the report recommends that, "Priority for research, therefore, should be given both to those disorders with the greatest burden of suffering and to those with the highest prevalence." The report then provides a list which includes such diverse disorders as autism, Tourette's disorder, and conduct disorders.

There is a concern, however, despite the reasonable criteria presented for establishing priorities, that in reality a disproportionate amount of research has historically been done (and may continue to be done) on disorders that lend themselves to clear and easy diagnosis, and ready access to cooperative subject populations, such as autism or Tourette's disorder. While additional research on these disorders is clearly needed, there is an enormous need for more research on problems like conduct disorder, which despite its significance to systems of care, appears to be under-studied. This is largely because it is not as easy to clearly diagnose as other disorders (in fact, diagnostic criteria and actual labels tend to change frequently over time), cooperative subject populations (particularly for longitudinal studies) are harder to find, and in general it doesn't lend itself as well to scientifically clean research as do other disorders.

Given this reality, and the parallel reality of the importance of these problems, there is a need to look specifically at the obstacles to research in certain areas, and to develop mechanisms to overcome them. It may in fact be that one of the obstacles is that certain conditions do not lend themselves to disorder-focused research as well as do others, and that unless the focus of research is broadened, they will continue to be understudied.

Leadership for Child Mental Health Research

The recommendation that NIMH establish an associate director for children and adolescents to provide full-time leadership in children's research is an important and valuable recommendation of the report. So is the identification of some of the early tasks that need to be undertaken out of that office. These include examining the process of initial review of research proposals, advocating with other federal agencies about the need for child and adolescent mental health research, and increasing the involvement of private foundations in this area.

The proposed associate director would establish an institute-wide consortium concerned with child and adolescent mental health research. Membership on the consortium "would consist of appointed representatives from each of the major research divisions within the extramural program as well as representatives from intramural research."

While the establishment of an associate director position, and such a consortium are excellent ideas, it is recommended here that representation on the consortium include the NIMH Division of Education and Service Systems Liaison. This Division has significant responsibility for planning, training and education, and service demonstration projects, and its representation would not only add an important perspective but be a step towards increasing communication between the research and the service system communities.

In fact, an overall theme that emerges from a service system perspective is the need for increased dialogue and collaboration between academic-based researchers, researchers in non-academic settings, mental health policy makers, and family members. The NIMH Public--Academic Liaison initiative is a very positive and important step in that direction. Such dialogue and collaboration needs to be focused on individual research projects but needs to be much broader as well. It should be incorporated in the training of researchers, the development of priorities for research, the creation of improved procedures for dissemination of research results, and the establishment of research policies as well.

The next few months, during which the IOM report wil be reviewed, and NIMH will be developing its National Plan for Research on Child and Adolescent Disorders, will be important in creating a much-enhanced capacity and vision for child mental health research. The IOM report has provided an excellent launching point for this process, but the ultimate success of the process will require the active participation and input of other individuals and organizations interested in children's mental health.

To offer comments for NIMH's consideration as it develops its plan write to Dr. Lewis Judd, Director, NIMH, Room 17-99, Rockville, MD 20857.

B. Friedman

RESOURCES UPDATE

Research and Training Center for Children's Mental Health

The Research and Training Center for Children's Mental Health (RTCCMH) of the Florida Mental Health Institute is funded by the National Institute on Disability and Rehabilitation Research and the National Institute of Mental Health. The RTCCMH mission is to improve services for children with emotional disturbances and their families by increasing the knowledge base for such services. As part of its commitment to this mission, RTCCMH provides a variety of training, consultation, and dissemination activities.

An Annotated Bibliography describing papers prepared by RTCCMH staff is available upon request. Copies of material or further information can be obtained from Dr. Al Duchnowski, Director of Training Consultation and Dissemination, RTCCMH, 13301 Bruce B. Downs Blvd., Tampa FL 33612, (813) 974-4500.

This newsletter is prepared by RTCCMH staff to provide information about developments in services for children with emotional disturbances and their families. We invite you to reproduce the material and distribute the information in any way you wish for the purpose of increasing knowledge about the needs and services in children's mental health.

We ask you to acknowledge the source, and let us know how you used it.

Thanks!

Minority Monographs

Two monographs on services for minority children with severe emotional disturbances have been released. "The Minority Severely Emotionally Disturbed Child: Considerations for Special Education and Mental Health Services," is a task force report recommending a CASSP network to publicize information on the needs of these children and the resources available to them. "Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed," provides a philosophical framework on improving the delivery of services to minority children. These monographs are available from the CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road, N.W., Washington, DC 20007, or call (202) 687-8635.

Conference Proceedings

The 1988 conference on, "Children's Mental Health Services and Policy: Building A Research Base" identified key research issues on children's mental health services and policy research. The proceedings are available for $10.65 from the Office of Training and Consultation, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899.

"Invisible Children" Project

A resource kit on the "Invisible Children" project conducted by the National Mental Health Association includes the final report and recommendations, a guide for advocates, and a copy of the project survey. The kit is available from NIMHA, 1021 Prince Street, Alexandria, VA 22314-2971 or call (703) 684-7722.

Special Journal Issue

The winter 1989 edition of the Journal of Mental Health Administration is a special issue devoted to children's mental health services. For a copy of the journal write Dr. Bruce L. Levin, Editor, Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL 33612 or call (813) 974-4500.

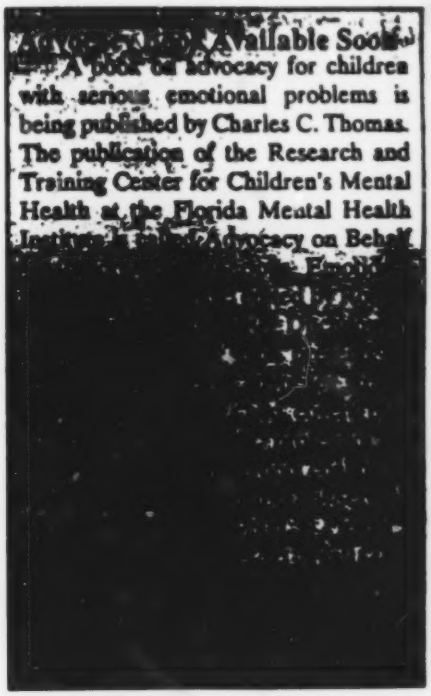
TASPP Activities

The Technical Assistance for Special Populations Program (TASPP), University of Illinois Office of the National Center for Research in Vocational Education, University of California, Berkeley has completed a resource guide on transition called "Resources to Facilitate the Transition of Learners with Special Needs from School to Work or Postsecondary Education." The guide lists handbooks, curriculum guides, projects, associations, journals, bibliographies and directories among other things. The $5 guide is available from NCRVE Materials Distribution Service Center, Western Illinois University Horrabin Hall 46, Macomb, IL 61455 or call 1-800-637-7652.

A pre-AVA conference focusing on Exemplary Vocation Education Programs and Practices for at-risk youth and adults, teen parents and linited English proficient will be held Nov. 30 and Dec. 1 in Orlando, Florida. For information on both conferences, call Dr. Carolyn Maddy-Bernstein, TASPP director or Tom Wermuth at (217) 333-0807 or write to TASPP, 345 Education Building, 1310 South Sixth Street, Champaign, IL 61820.

Addiction Conference

Community Program Innovations will hold it's seventh annual conference, "The War Against Ourselves: Addiction and Violence" on Nov. 29, 30, and Dec. 1 at the Tremont House in Boston. For more information write Community Program Innovations, P.O. Box 2066, Danvers, MA 01923 or call (508) 774-0815.


Available Soon
A book on advocacy for children with serious emotional problems is being published by Charles C. Thomas. The publication of the Research and Training Center for Children's Mental Health at the Florida Mental Health

BEST COPY AVAILABLE

BEST COPY AVAILABLE

Changing Faces

Robert Davila

Michael E. Vader

James Stockdill

Three people were recently approved for positions in the United States Department of Education, Office of the Assistant Secretary for Special Education and Rehabilitative Services (OSERS).

Robert Davila, Ph.D., is the new Assistant Secretary of OSERS. He last served as Vice President for Pre-College Programs at Gallaudet University since 1978.

Michael E. Vader will serve as the new Deputy Assistant Secretary of OSERS. He most recently served as Deputy Director of of the Department of Consumer Affairs for the State of California.

Judy Schrag is the new Director of the Office of Special Education Programs of OSERS. She last served as Assistant Superintendent of Public Instruction since 1980 in Washington state.

James Stockdill, Director of the Division of Education and Service Systems Liasion of the National Institute of Mental Health (NIMH) for eight-and-a-half years, resigned as of July 31, 1989. He had held this position during the entire development of the CASSP Program and had been with NIMH for 20 of the last 23 years. Ernest Hurst, who had served as Deputy Director of the Division of Education and Service Systems Liasion, will serve as Acting Director.

Interagency Collaboration References and Resources

Alaska. Information available from John VanDenBerg, Child and Adolescent Mental Health, Division of Mental Health and Developmental Disabilities, P.O. Box H-04, Juneau, AK 99811.

Contra Costa, California. Information available from Bill Wridinger, Contra Costa Social Service Dept. 4545 Delta Fair Blvd., Antioch, CA 94509.

Florida Multiagency Network for Severely Emotionally Disturbed Students -- An Overview 1982-1987. Information available from Lee Clark, Dept. of Education, Knott Bldg., Tallahassee, FL 32301.

Hinckley, E. C. (September-October 1984). Homebuilders: The Maine Experience. Children Today, 14-17.

"Keeping Families Together", which summarizes successful family preservation programs, is available free with a self-addressed mailing label from the Edna McConnell Clark Foundation, 250 Park Avenue, New York, NY 10017.

Kentucky. Information available from Paul Andrea, Director, Children and Youth Branch, Dept. for MH/MR Services, Health Services Bldg., 275 E. Main Street, Frankfort, KY 40621.

Kinney, J.; Haapala, D.; Booth, C. & Leavitt, S. (1988). The Homebuilders Model. In J. K. Whittaker, J. Kinney, E. M. Tracy, & C. Booth (Eds.) Improving practice technology for work with high risk families: Lessons from the "Homebuilders" Social Work Education Project (pp. 179-190). Seattle, WA: University of Washington School of Social Work.

Knitzer, J. (1989). Collaboration Between Child Welfare and Mental Health: Emerging Patterns and Challenges. New York: Bank Street College.

Knitzer, J. & Cole, E. S. (1989a). Family Preservation Services: The Program Challenge for Child Welfare and Child Mental Health Agencies. New York: Bank Street College.

Knitzer, J. & Cole, E. S. (1989b). Family Preservation Services: The Policy Challenge for Child Welfare and Child Mental Health Agencies. New York: Bank Street College.

New York Family Based Treatment Program. Year End Report, 1989. For information contact Gloria Newton-Langston, Assoc. Com., Bureau of Children and Families, Office of Mental Health, 44 Holland Ave., Albany, NY 12229.

Nevada. Information available from Christa Peterson, Clinic Director, Southern Nevada Child and Adolescent Services, 6171 W. Charleston Blvd., Las Vegas, NV 89158.

North Carolina. Information available from Lenore Behar, Special Assistant for Child and Family Services, Division of MH/MR/SAS. Dept. of Human Resources, 325 N. Salisbury Street, Raleigh, NC 27611.

Ohio. Information available from Patrick Kanary, Chief, Bureau of Children's Services, Dept. of Mental Health, 30 East Broad Street, Columbus, OH 43215.

South Carolina. Information available from Jerome Hanley, Director, Mental Health Youth Services, Dept. of Mental Health, 2415 Bell Street, Box 495, Columbia, SC 29202.

Ventura County Children's Mental Health Services Demonstration Project. (1987). AB 377 Report on the Ventura County Mental Health Demonstration Project: A 27 month update and addendum to the two year report on the Ventura Model for Interagency Children's Mental Health Services, Ventura, CA: Author.

Vermont. Information available from Linda Taft, Mental Health Children's Specialist, Dept. of Mental Health, 103 S. Main Street, Waterbury, VT 05676.

Virginia State Interagency Consortium on Severely Emotionally Disturbed Children and Adolescents (1988, October). Briefing paper FY 88, operations executive summary.

Washington State. Information available from Richard Westgard, CASSP Project Director, Dept. of Social and Health Services, Mental Health Division, Mailstop: OB-42F, Olympia, WA 98504.

Yelton, S. W. (Summer 1988). Child Protective Services and Child Mental Health -- Partners in Family Preservation. Protecting Children. American Association for Protecting Children. pp. 13-14 and 18.

OTA Report Due in 1990

A study on adolescent health being conducted by the U.S. Office of Technology Assessment (OTA) at the request of Congress is not expected to be released until the summer of 1990, according to Kirsten Rowe, an OTA analyst in the Health Program Office. The [illegible] special section on [illegible] health.

NGA

Continued from page 1.

foster care, day treatment, intensive home-based services, respite care, mobile crisis services and case management. "Current mental health programs focus too heavily on either outpatient counseling, which is often limited, or on inpatient/residential beds," according to the report.

The NGA emphasizes the need for joint planning, program development, and funding by various child-serving agencies.

"More than any other single factor, the methods of funding mental health and related services have limited the state ability to provide responsive and effective mental health services," the statement indicates. "Present federal and state funding streams encourage discrete and categorical support that is too rigid to respond to complex individual needs." The report calls for more flexibility in funding, and in public and private insurance, an increased funding focus on community-based services rather than inpatient care.

The NGA calls for more research, program evaluation and advocacy for children with serious emotional disturbances.

A need for improved relations between universities and public agencies involved with these children is also identified. The statement indicates that, "States should work with universities to enhance their understanding of and responsiveness to children with serious emotional disturbances and the publicly funded systems that serve them."

Copies of the policy statement are available from NGA at 444 N. Capital St. NW, Suite 250, Washington, D.C. 20001 (202) 624-5300.

IOM Report

Continued from page 1.

Judd reports that the National Advisory Mental Health Council is in the process of developing a "National Plan for Research on Child and Adolescent Disorders," using the IOM report as a key resource. The completed National Plan will be presented at the Council's February, 1990 meeting.

Committee Chair Leckman indicates that he is very encouraged by the total support from NIMH's Council, and the support received from the field in general.

Commenting on the recommendations, Leckman notes that the highest priority is increased "support for people at the beginning of their research careers who had received good training." He indicated that, given the need for considerably more research, "the biggest tragedy is when you have people who have been through training, and then have limited opportunity to do research."

In addition to calling for increased support for research training, and for the research itself, the report also recommends the establishment of an institute-wide consortium concerned with child and adolescent research at NIMH. It says that "an associate director of NIMH for children and adolescents should provide full-time leadership for the consortium." (For further analysis, see the article on page 20.)

NIMH has indicated its interest in receiving comments to assure that the National Plan it is developing "adequately reflects the most important research priorities of the field." These comments should be sent to Dr. Lewis Judd, Director, NIMH, Room 17-99, 5600 Fishers Lane, Rockville, MD 20857. Copies of the full IOM report are available from the National Academy Press, 2101 Constitution Ave., NW, Washington, D.C. 20418 or call (202) 334-3790. Individual copies are $3.

Events, activities, programs, and facilities of the University of South Florida are available to all without regard to race, color, sex, religion, national origin, Vietnam or disabled veterans status, handicap, or age, as provided by law and in accordance with the University's respect for personal dignity.

This public document was promulgated at an annual cost of $20,560 or $.51 per copy including preparation, printing, and distribution, to provide information about mental health services for children and the activities of the Research and Training Center for Children's Mental Health, FMHI, USF. [90-19]

UPDATE

Research and Training Center for Children's Mental Health
Florida Mental Health Institute
13301 Bruce B. Downs Blvd.
Tampa, Florida 33612-3899
813/974-4500

Non-Profit Org.
U.S. POSTAGE PAID
at Tampa, Florida
Permit No. 257

Forwarding and Address Correction Requested

BEST COPY AVAILABLE

Florida Mental Health Institute, University of South Florida, Tampa, Florida

UPDATE

Improving Services for Emotionally Disturbed Children

VOLUME 6, NUMBER 1 SUMMER 1990

Congress Considers Children's MH Services Bill

Members of Congress are being asked to support a new children's mental health proposal that would provide grants to states for children's mental health services.

The Child Mental Health Services proposal was created by an ad-hoc coalition of national child advocacy and mental health groups spearheaded by Chris Koyanagi of the National Mental Health Association (NMHA). The proposal is based on the recommendations of parents, advocates, child mental health researchers, scientists, and other professionals.

Preliminary hearings were held April 30 before the Subcommittee on Health and Environment of the U.S. House of Representatives Committee on Energy and Commerce. Testifying before this committee, chaired by Rep. Henry A. Waxman of California, were B. R. (Pete) Kennemer, of Fort Smith, AR, representing the National Council of Community Mental Health; Marissa Brown, of Virginia Parents and Children Coping Together; Dr. Bob Friedman of the Research and Training Center for Children's Mental Health, and Koyanagi.

The proposal, called the "Children's and Communities' Mental Health Services Improvement Act of 1990" in draft language, was strongly supported by each of the witnesses testifying before the Committee. Koyanagi indicated that while there has been much progress in the children's mental health field "to move beyond the planning and basic state interagency discussion stage, we need an infusion of funds to start up the innovative services and develop the complete community systems of care that will enable us to help these children."

Chris Koyanagi, National Mental Health Association and Dr. Robert Friedman, Research and Training Center for Children's Mental Health, give testimony before the Subcommittee on Health and Environment of the U.S. House of Representatives Committee on Energy and Commerce.

The proposal would create the only pool of federal dollars targeted to help states and communities create mental health service components that are necessary to complete the system of care for children and youth who have severe mental or emotional disabilities, according to Ellen B. Kagen, Assistant Director for Technical Assistance of the CASSP (Child and Adolescent Service System Project) Technical Assistance Center.

In the proposal, states would be awarded five year grants on a competitive basis and would be required to provide a 25 percent state match for the federal money. At least 10 states would be funded the first year with $100 million. The authorization would grow to $200 million in the second year and $300 million in the third year.

The grants would be used to provide a range of community services including:

- day treatment
- case management
- home-based child and family services
- respite care
- family-based crisis and other emergency services
- therapeutic foster care
- therapeutic group homes
- programs for transitions into adult services or independent living.

If the Child Mental Health Services proposal passes, states would be required to demonstrate parental involvement in planning and follow the principals of CASSP in developing local systems of care, in order to receive funding. All relevant child-serving agencies such as education, child welfare, and juvenile justice would have to be involved in the implementation of the program.

Continued on Page 7.

NEWS UPDATES

Medicaid Changes	2
Research Plan	3
Respite Care	6
Robert Wood Johnson Grants	7
Minority Initiative	8
Discarded Children	13

DEPARTMENT UPDATES

Education	4
Conference Summary	9
Program Update	10
Cross Country	14
Resources	18

RESEARCH AND TRAINING
CENTER FOR CHILDREN'S
MENTAL HEALTH

UNIVERSITY OF SOUTH FLORIDA
FLORIDA MENTAL HEALTH INSTITUTE
13301 Bruce B. Downs Blvd.
Tampa, Florida 33612-3899
(813) 974-4599

ADVISORY BOARD MEMBERS
CHRISTINA K. YOUNG, CHAIRPERSON
Stowe, Ohio
LENORE BEHAR, PH.D.
Dept. of Human Resources
Raleigh, North Carolina
COLLEEN L. BEVIS
Tampa, Florida
ROBERT E. BRABHAM, PH.D.
National Rehabilitation Association
Alexandria, Virginia
BARBARA J. BURNS, PH.D.
Duke University Medical Center
Durham, North Carolina
WILLIAM BUSCHANY, M.D.
Mendota Mental Health Institute
Madison, Wisconsin
EUGENIA CLARK
Tampa, Florida
JOHN CLARK
Dept. of Education
Lincoln, Nebraska
ELIZABETH S. COLE
New Hope, Pennsylvania
KARL W. DENNIS
Kaleidoscope
Chicago, Illinois
STEVEN R. FORNESS, ED.D.
University of California
Los Angeles, California
GLORIA M. GRAVES
Topeka, Kansas
MARIO HERNANDEZ, PH.D.
Ventura County Mental Health
Ventura, California
GWEN IDING
Homosassa Springs, Florida
DIXIE JORDAN
PACER Center
Minneapolis, Minnesota
JANE KNITZER, ED.D.
Children's Defense Fund
New York, New York
CHRIS KOYANAGI
National Mental Health Association
Alexandria, Virginia
BRENDA LYLES, PH.D.
C.A.M.
New Orleans, Louisiana
JO M. PIKE, M.S.W.
Mental Health Association of LA
Baton Rouge, Louisiana
HERBERT C. QUAY, PH.D.
University of Miami
Coral Gables, Florida
BARBARA STARFIELD, M.D., M.P.H.
The Johns Hopkins University
Baltimore, Maryland
JUDITH A. STURTEVANT
Morrisville, Vermont
CHRIS A. ZEIGLER-DENDY, M.S.
Lawrenceville, Georgia

U.S.F. ADVISORS
SUE BISHOP, PH.D., R.N.
ADLAI BOYD, PH.D.
RICHARD DEMBO, PH.D.
WILLIAM G. EMENER, PH.D.
BETTY C. EPANCHIN, ED.D.
HOWARD M. KNOFF, PH.D.
ARCHIE A. SILVER, M.D.
JUEL SMITH, PH.D.

CENTER STAFF
ROBERT M. FRIEDMAN, PH.D.
Executive Director
ALBERT DUCHNOWSKI, PH.D.
Director, Training, Consultation, & Dissemination
STARR SILVER, PH.D.
Director, Epidemiological Research
KRISTA KUTASH, M.B.A.
Administrative Director
ALISSA ALGARIN, B.S.
UPDATE Editor
KELLY M. ENZOR
Assistant Editor

Medicaid Changes Provide Opportunity for More Services

Significant changes in health coverage for low income children, enacted by the U.S. Congress last November as part of the Omnibus Budget Reconciliation Act of 1989, may expand mental health services, according to several experts in the field.

Health policy consultant Harriette Fox, in a January, 1990 report on the changes to the Medicaid program, stated that the potential impact of the changes "on children's health care can not be overstated." Chris Koyanagi of the National Mental Health Association (NMHA) said the changes create "a very exciting opportunity for states to expand their Medicaid programs to improve services for the mental health population."

Medicaid is a federal-state cost sharing program composed of a combination of mandatory and optional services designed to provide health services for low income individuals. The most significant changes in the recent legislation take place in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) component of the Medicaid program, a mandatory component of state Medicaid programs that was enacted by Congress in 1967.

The purpose of EPSDT was "to assure that all Medicaid-eligible children age 0 to 21 receive a broad range of primary and preventive health services including regular well-child exams, dental care, and treatment for medical problems," according to the Children's Defense Fund (CDF).

In the past, the effectiveness of EPSDT in identifying and treating children's mental health needs has been limited "because states have not ensured that all children are screened regularly, have not included mental health factors in their screenings, and have not taken advantage of a federal law option which allowed them to provide expanded services to children who had received an EPSDT screening," according to the NMHA.

However, the recent changes will now require states to:

- assess both physical and mental health development;
- provide partial and extra screenings above and beyond the regular screenings, whenever such a screening is determined to be medically necessary by a qualified professional;
- reimburse all related treatment services allowed under federal Medicaid law, when such services are identified as needed by the EPSDT screen, whether or not these services are part of the state's Medicaid plan.

According to CDF, requiring states to pay for screening services at intervals in addition to their basic periodicity schedule corrects the previously existing problem "that a child who is not due for an EPSDT screening visit, yet has a new (or worse) condition, may not be able to get necessary care." Now, for example, a six-year-old child who is identified by a teacher as potentially having a developmental problem can be immediately referred to the nurse and to an EPSDT provider for assessment, diagnostic, and treatment services even if the state's periodicity schedule does not call for a re-examination for another year.

The changes make it possible for Medicaid-eligible children to receive a more expanded range of home and community-based services than currently exist in most state plans. In fact, according to Fox, the changes "are of particular importance for children who require less traditional interventions or intensive, on-going treatment and who often have found the services they require to be entirely unavailable under the state Medicaid plan or else to be offered in insufficient amount, duration, or scope." This includes such services as home-based treatment, case management, respite care, day treatment, and therapeutic foster care.

Koyanagi cautions that this change is going to be a very expensive proposition for many states, and that "it may result in reduced funding in other areas, and mental health services may be particularly vulnerable to reduction."

Further information about the changes can be obtained from the CASSP Technical Assistance Center, Georgetown University Child Development Center, 2233 Wisconsin Ave., NW, Suite 215, Washington, DC 20007, the National Mental Health Association, Department of Public Policy, 1021 Prince Street, Alexandria, VA 22314; and the Children's Defense Fund, 122 C St., NW, Washington, DC 20001.

BEST COPY AVAILABLE

Child Research Plan Presented to Congress

"Scientific effort and progress in understanding and treating the mental disorders of children and adolescents have not kept pace with the scope of the problem, the urgent need for answers and action, and the scientific field's readiness to move forward," according to a National Advisory Mental Health Council (NAMHC) report presented to Congress in March, 1990. Therefore the council requested an immediate $60 million increase in expenditures for research on child and adolescent mental disorders.

The council's report is based on a document released in June, 1989, by the Institute of Medicine (IOM) of the National Academy of Sciences, prepared at the request of the National Institute of Mental Health (NIMH). In the summer of 1989, following the release of the IOM report, the House Committee on Appropriations and the Senate Committee on Appropriations both requested that a national plan be developed to implement the recommendations of the IOM report.

That report, prepared by a committee of the NAMHC chaired by Dr. Felton Earls of Harvard University, went beyond the IOM report in its recommended level of funding. The NAMHC report calls for a funding level of $152.5 million during Fiscal Year 1991, the first year the plan would be in effect, with an increase by the end of the fifth year to $283.3 million. The IOM report, in contrast, called for funding levels of $111 million during the first year and $198.5 million in the fifth year.

Described as a "strategy to accelerate progress in understanding child and adolescent mental disorders," the plan uses the IOM report as a base and includes recommendations in the areas of clinical research, basic research, research on services, research career development and research training support, the NIMH intramural program, and dissemination of scientific knowledge.

The largest increases would come in the clinical research and basic research areas ($61 million each over the five years). Also, $33 million is proposed to support the development of researchers, and $19 million more for research on services.

The plan indicates that, "The well-being of our Nation depends on the health and strengths of our young people...The tragic consequences of mental disorders in our youth — derailed young lives, unfulfilled potential, later drug abuse and crime, and even suicide — represent an intolerable waste of our Nation's present and future capabilities. We must do something about this situation now, and we can."

Dr. Lewis Judd, Director of NIMH, who requested that the child research plan be developed.

A summary of the plan was presented in a Congressional briefing, organized by the National Mental Health Association, on March 16, 1990. Presentations were made by Dr. Lewis Judd of NIMH, Dr. James Leckman of Yale University, Dr. Bob Friedman of the University of South Florida, Dr. Joseph Coyle of the Johns Hopkins University, and L. Patt Franciosi of the National Mental Health Association.

The report is now under study by Congress. Further information about the NAMHC plan can be obtained by writing the council at 5600 Fishers Lane, Parklawn Building, Room 9105, Rockville, MD, 20857.

Advocacy Groups Make Children a Priority

Mental health advocacy organizations are making mental health policies for children a top priority.

L.Patt Franciosi, president of the National Mental Health Association, has made children's mental health a major goal for the association in 1990.

In her address to the membership last year, Franciosi called children's mental health needs the most serious problem facing the nation.

"Whatever the label or reason, there are between 7 and 9 million children with serious emotional problems. Incredibly, and to our national shame, 70 to 80 percent of them receive no appropriate mental health services," she said.

The association has launched a national public education and awareness campaign, "Remember the Children," during May, 1990, for Mental Health Month. Franciosi's plans for the year include building broad based coalitions across the country, forming a nationwide advocacy network for parents, and founding an Office of Children and Adolescents within the association's National Public Policy Department.

NMHA also sponsors a Child Mental Health Interest Group, a non-partisan Congressional spouses group chaired by Tipper Gore and Ann Simpson. The 31 member Congressional spouses group is holding an educational conference series on children's mental health issues.

The National Alliance of the Mentally Ill Child and Adolescent Network, (NAMI CAN) sponsored a Child and Adolescent Leadership Training Conference May 4-6, 1990. The conference discussed obstacles to gaining services such as transfer of custody requirements, finding financial resources, and preventing burnout.

NAMI CAN focuses on children and strives to help children with mental illness sess and their families through advocacy, public education, and family-to-family support.

For more information on the activities of NMHA and the Congressional Spouses group write the NMHA at 1021 Prince Street, Alexandria, VA 22314-2971 or call (703) 684-7722. For information on NAMI CAN write NAMI 2101 Wilson Blvd., Suite 302, Arlington, VA 22201 or call (703) 524-7600.

EDUCATION

Congress Studies Re-Authorization of PL 94-142

A Senate bill which reauthorizes programs in the Education for the Handicapped Act includes a new program for children with serious emotional disturbances.

The bill, S 1824, which passed the Senate on November 16, 1989, will provide $28 million over the next five years for activities that focus directly on children with serious emotional disturbance.

A draft of a similar bill was expected to be finalized in the House in April and be brought to the full committee on May 15.

The Senate bill requires the Department of Education to fund a variety of programs over the next five years. Those include:

- Studies on special education and related services for children and youth with serious emotional disturbances and the creation of a data base to assess those services over time.
- Projects to develop ways to improve special education and related services.
- Projects to develop approaches to reduce the use of out-of-community placements and to increase the use of day treatment, after-school and summer programs.
- Projects to develop effective collaboration among special education, regular education, and related services professionals.
- Projects to develop innovative approaches to prevent children who have emotional and behavioral problems from developing serious emotional disturbances that require special education.
- A study of out-of-community residential placements, the extent to which children return to their communities, and factors which facilitate or impede their return.

Senator Tom Harkin (D-IA), sponsor of Senate Bill 1824.

The Senate bill will renew until 1994 a federal discretionary grant program which funds research, training, and demonstration initiatives under P.L. 94-142. P.L. 94-142 gives children with disabilities the right to a free and appropriate education.

Senator Tom Harkin (D-IA) sponsored the bill and said that testimony given by the Mental Health and Special Education Coalition in April, 1989 spurred the addition of the programs for children and youth with serious emotional disturbances.

"Testimony delivered at the April hearing made it clear that students with severe emotional disturbances remain significantly under-served or unserved by the special education system... The reauthorization gives us the opportunity to address this long neglected problem."

COALITION HAS BUSY AGENDA

The National Mental Health-Special Education Coalition continues to make progress on an ambitious list of activities which are planned to improve services for children who are identified as having serious emotional disturbances in the nation's public schools. Joe Ballard, of The Council for Exceptional Children, has replaced Fred Weintraub as co-chair, while Chris Koyanagi of The National Mental Health Association continues in her role as the other co-chair.

Since the last meeting of the entire Coalition in December, 1989, sub-committees have been carrying out specific assignments. At the December meeting, Dr. Judy Schrag, Director of the Office of Special Education Programs, requested input from the Coalition through a committee that would meet with her and her staff. The Coalition welcomed this opportunity and has begun such meetings. The Coalition has targeted three specific areas of immediate concern: increased identification and delivery of appropriate services; parent involvement and support; and improved educational outcomes and transition from school.

The legislative committee has been the most active, focusing on strengthening service for children who have serious emotional problems through the Education of the Handicapped Act (PL 94-142). This federal law is being prepared for re-authorization and an opportunity exists to incorporate recommendations from the Coalition into the new law.

One particular goal of the Coalition is to ensure that more discretionary money allocated through PL 94-142 will be used for children with emotional handicaps. The Coalition is recommending, for example, that this money is a potential source for funding collaborative activities that may be program demonstations of state-of-the-art service models.

For more information on the Coalition, contact Chris Koyanagi, Director, Federal Relations, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-7722 (703) 684-7722.

SED Enrollment Grows Slightly

Children who have serious emotional disturbances continue to fare poorly in education when compared to other groups of handicapped youths, according to data from the "Eleventh Annual Report to Congress on the Implementation of the Education of the Handicapped Act."

The 1989 report indicates that while the increase of children served for all conditions was 1.2% over one year, the increase for children who have serious emotional problems was 0.7%. By comparison, there was an increase of 2.0% for children with learning disabilities and 1.9% for speech impaired.

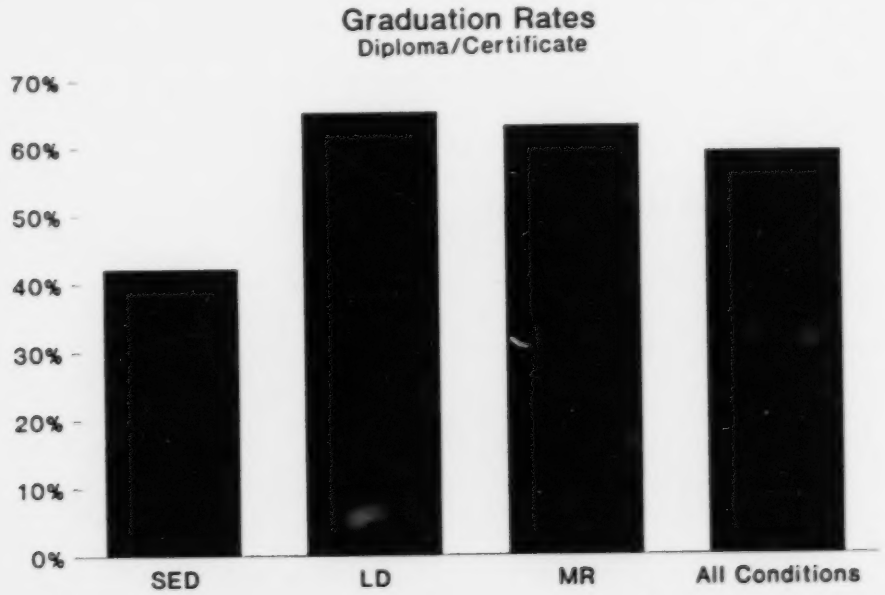
These data, from the 1987-1988 school year, also indicate a continued wide variance between states. For the seriously emotionally disturbed category, the range is 0.04% to 2.46% served. Unlike past years, the states no longer report pre-school data by exceptionality. Consequently, comparisons were only made for the age group 6-17. The percent of children enrolled, aged 6-17, who were served under the category of serious emotional disturbance during '87-'88, is 0.66% compared to 0.57% in '86-'87.

The problems that students with serious emotional disturbances face persist after they leave school. The report presents detailed results of a longitudinal study by SRI of special education students who have transitioned out of school. The study looked at variables from living arrangements to self-care skills and found that students who have serious emotional problems have the lowest full-time employment of all the major exceptionalities, for students who have been out of school longer than one year.

As in the last report, exit and placement data reveal that children with emotional problems fare poorly. Table One shows that this group of students has a graduation rate of 42%, compared to 59% for all exceptionalities. This is the lowest rate for the major exceptionalities.

In terms of placement, 93% of all exceptional students receive their education in a regular school building, while the rate is 81% for children who have emotional problems. In addition, 2% of the identified children with serious emotional disturbance are in correctional facilities compared to 0.03% for all conditions.

Copies of the report may be obtained from the Office of Special Education and Rehabilitative Services, Switzer Building, 330 C Street SW, Washington, DC 20202.



OSERS Family Leadership Conference

The Office of Special Education and Rehabilitative Services (OSERS) of the U.S. Department of Education learned how families visualize the future at a conference held January 8 - 9, 1990 in Washington, DC.

Family leaders presented their visions for their sons and daughters with disabilities and discussed what types of research, training, and services OSERS should strive to have in place by the Year 2000.

National leaders reviewed goals developed by the new OSERS Management Team, headed by Assistant Secretary Robert R. Davila. The team and families discussed how OSERS' programs can best reflect state-of-the-art research, training, and services for children and adults with disabilities and their families.

This meeting was the initial step in a multi-plan, goal-setting process that Davila plans to take to a variety of OSERS' constituents. Davila said that it is "essential to have an on-going, collaborative relationship between OSERS and families."

Conference participants had the opportunity to interact with Michael Vader, the Deputy Assistant Secretary for OSERS and with the leaders of OSERS' three components: James Reswick, Acting Director of the National Institute on Disability and Rehabilitation Research (NIDRR); Judy Schrag, Director of the Office of Special Education Programs (OSEP); and Nell Carney, Commissioner of the Rehabilitation Services Administration (RSA).

Barbara Huff, President of the Federation of Families for Children's Mental Health, left the meeting feeling that it had established a positive working relationship between families and OSERS. "I think that we are off to a good start," Huff said, "and I am very hopeful about long term collaboration."

For more information, contact OSERS at 400 Maryland Ave. SW, Washington, DC 20202 or call (202) 732-1265.

Conference Emphasizes Need for Respite Care

A diversity of services is needed for respite care, said presenters at a national conference, "Respite Care: A Key Ingredient of Family Support," held October 28-30, 1989 in Covington, Kentucky. Respite care provides caretakers of children and adolescents with serious emotional disturbances with support so they can have temporary rest and relief from caring for the child.

Services should be provided so that as many families as possible can use respite care, said Terry Butler, Coordinator of Multnomah County Connections Program in Portland, Oregon. "The themes or characteristics are diversity, flexibility, and accessibility," he said.

Butler said respite services can be provided either in the child's home or outside of the home.

"Perhaps our long-range task really is to develop a system of respite care in the context of family support," Butler said.

Barbara Huff, Executive Director of Keys for Networking in Topeka, Kansas and president of the Federation for Children's Mental Health, said respite care has to be affordable for families and agencies that provide service need to be flexible.

Creasa Reed, a parent consultant with the Department of Mental Health in Frankfort, Kentucky, said respite should be unique and individualized and should be culturally appropriate. She is upset when there is a lack of respite care available.

"I get angry and I get mad and I get disgusted and I cry when people have to put their kids in hospitals because they don't have any respite," she said. "I don't think that should ever have to happen."

The Research and Training Center on Family Support and Children's Mental Health at Portland State University, sponsored the conference in collaboration with the Child and Adolescent Service System Programs (CASSP) in a number of states. The Kentucky and Ohio CASSP projects hosted the conference. Co-sponsors were CASSP projects in Indiana, Illinois, Kansas, Kentucky, Ohio, Oklahoma, West Virginia, and Wisconsin.

Approximately 200 people from 36 states attended. About 40 percent were family members. Most participants were members of state delegations organized through state mental health programs.

The goals of the conference were to provide information about respite care concepts, programs, and issues and to help participants develop plans for designing, financing, and implementing respite programs in their states and communities.

The Portland Research and Training Center on Family Support and Children's Mental Health will publish conference proceedings. For further information, write Publications Coordinator, Research and Training Center on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, OR 97207-0751.

Study Examines Coordination of Children's Services

In a survey of states' efforts to coordinate the delivery of services to children and youth, the Child Welfare League of America (CWLA) has found that more than one-half of states are studying issues related to coordination and are trying to craft innovative solutions.

The group plans to use information gathered in the survey to convince legislators to pass the Young American's Act, an act that would establish an Administration on Children, Youth and Families within the Department of Health and Human Services. The plan would give states the flexibility to develop their own comprehensive, coordinated, planning and support services to children and youth.

The CWLA has been collecting survey information over the past year. "This is the kind of activity that an Administration on Children, Youth and Families could be doing," said Tess Scannell, Senior Policy Analyst for the CWLA.

The preliminary findings show that only three states have state level departments which provide integrated services to children and youth: Connecticut, Delaware, and Rhode Island. These states provide integrated services in three areas: child welfare (including protective services), mental health, and juvenile delinquency.

Twelve states have task forces charged with the coordination of services. For example, North Dakota created a coordinating committee, chaired by the Lieutenant Governor, charged with developing a plan of interagency service delivery. Many states' task forces are devoted to specific issues, such as delinquency, child abuse, and health education.

Sixteen states have study groups on the issue of coordination, usually in the form of a "Governor's Council" on a specific issue. Three states are currently reorganizing their entire state governments with plans to merge children's services into one agency.

Scannell said there is currently no national information available on children's services. "There is no data base. There is no way to know what is going on around the country," she said.

CWLA member agencies say there is a need for federal leadership on the issue of coordination. They echo the National Governors' Association Task Force on Children which called on the federal government to develop a coherent national children's policy based on prevention and to streamline funding which it called convoluted and restrictive. The Young American's Act would provide for some direction and a statutory base for the Administration on Children, Youth and Families.

The Young American's Act would authorize grants to states for state and community programs for children, youth and families and for supportive services to demonstrate methods of filling service gaps identified in the planning and advocacy process. The Congressional Budget Office estimated the cost of the bill to be $20 million.

For more information on the act, contact the Child Welfare League of America, 440 First Street, NW, Suite 310, Washington, DC 20001-2085.

Michael Beachler, Program Officer for the Robert Wood Johnson Foundation.

RWJ Set to Award Grants

The twelve sites that received a Robert Wood Johnson Foundation Grant to improve services for children and youth with serious emotional disturbances in July, 1989, have submitted reports on their accomplishments over the past year, said Michael Beachler, Program Officer for the foundation.

During March and April each site was visited by members of the National Advisory Committee.

By July, the number of sites will be narrowed down to eight. Each of the eight states chosen will receive a four-year grant of up to $2.4 million to implement their programs.

The twelve sites are California, the District of Columbia, Kentucky, Michigan, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Washington, Wisconsin, and Vermont.

"We are pleased with the progress of grantees to date in getting people employed and pulling together the things needed to implement the plans," Beachler said. Through the planning, some of the grantees have found opportunities they did not know were available before, Beachler said.

The grant program is to encourage multi-agency, state-community partnerships to improve services for children and youth with serious mental illness.

For more information on the program, contact Dr. Mary Jane England, Prudential Insurance Company, 56 N. Livingston Ave. Roseland, NJ 07069, or call (201) 716-6882.

Children's Bill

Continued from page 1.

"CASSP has helped the process of system development in many states — now is the time for the development of services," Kagen said.

Mary Lee Allen, director of Child Welfare and Mental Health for the Children's Defense Fund, views the mental health services proposal as a "CASSP follow-up". She said now that CASSP has spent five years preparing systems in states, more money is needed to continue CASSP.

The National Association of State Mental Health Program Directors (NASMHPD) has issued a resolution supporting the federal grant initiative. The resolution states that while proven and innovative service technologies have become available for states, federal dollars for mental health services for children have steadily decreased. NASMHPD has resolved to urge Congress to act favorably upon the proposal.

The Child Mental Health Services Proposal is one of 40 initiatives that are being forwarded as proposals to improve the continuum of services for child welfare, mental health, and juvenile justice. The proposals are aimed at strengthening families and preventing child abuse and neglect, preventing unnecessary out-of-home care, improving the quality of out-of-home care, enhancing adoption assistance, expanding independent living activities, and strengthening service delivery.

For more information on the Child Mental Health Services Proposal, write the Department of Public Policy, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971 or call (703) 684-7722.

These National Organizations Have Endorsed the Child Mental Health Services Proposal:

American Academy of Child and Adolescent Psychiatry
American Association of Children's Residential Centers
American Association for Counseling and Development
American Orthopsychiatric Association
American Psychiatric Association
American Psychological Association
Children's Defense Fund
Council for Children with Behavioral Disorders
Council for Exceptional Children
Federation of Families for Children's Mental Health
Mental Health Law Project
National Association for Family-Based Services (Board)
National Association of Protection and Advocacy Systems
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Center for Clinical Infant Programs
National Council of Community Mental Health Centers
National Council of Juvenile and Family Court Judges
National Council of State Legislators, Children, Family and Social Services Committee
National Court Appointed Special Advocate Association
National Mental Health Association
State Mental Health Representatives for Children and Youth (A Division of NASMHPD)

Conferees Meet to Discuss Clinical Training

A national conference, held in September, 1989, in Washington, D.C. focused on the need to increase the consistency between university-based professional training programs and the vision of community-based systems of care developed by the Child and Adolescent Service System Program (CASSP).

The conference was co-sponsored by the CASSP Technical Assistance Center at Georgetown University, the Clinical Training Branch of the National Institute of Mental Health (NIMH), and the Child and Family Support Branch of the NIMH.

Dr. Jane Knitzer of New York described the type of system of care that is needed to serve children with serious emotional disorders and their families to the conference attendees, which included representatives of all of the major mental health disciplines. Knitzer emphasized the need for university-based training programs to strengthen their focus on new, community-based services, on changed roles for parents, and on collaborative efforts between different agencies.

Dr. John Gates of Georgia indicated that from his perspective as a director of a state department of mental health it was absolutely essential that a stronger partnership be established between the public and academic sectors.

Participants spent much of their time in small groups developing strategies and recommendations for increasing the relevance of professional training to the needs of the youngsters and families who are being served within the public mental health system.

Some of the recommendations were incorporated in the call for clinical training grant proposals issued by the NIMH in December, 1989. A total of 63 proposals focusing on children were received.

A summary of the conference along with recommendations will be available from the CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road NW, Washington, DC 20007.

Minority Initiative Studies Programs

There has been an overwhelming response to a search for exemplary culturally competent programs for children with serious emotional disturbances being made by the CASSP (Child and Adolescent Service System Program) Technical Assistance Center at Georgetown University, said Marva Benjamin, Project Coordinator.

More than 130 programs have been nominated by various project directors, mental health professionals, and minority consultants across the country, Benjamin said. Approximately 1,400 nomination forms have been distributed through a variety of state and federal mental health programs, state and national associations, and at conferences throughout the country.

Marva Benjamin, Project Coordinator for the CASSP Technical Assistance Center at Georgetown University.

Benjamin said she did not expect to receive as many nominations as she did. "This shows that there is a great deal of interest in trying to improve the system of care," she said. "There are some grass roots programs, especially in rural and southern areas where people have been utilizing their own community resources. They have been providing services to kids that the system has had a hard time reaching."

Sixteen programs including five alternate sites were recommended as study sites. Visits to 11 sites were made in March and April, 1990, Benjamin said.

The nominations were based on programs which showed an outstanding policy and clinical program, had high consumer satisfaction, and followed the principles of a culturally competent system of care as outlined in Towards A Culturally Competent System of Care - A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.

The principles in the monograph include: having the family as the primary system of support and point of intervention; having the practice in the system of care driven by culturally preferred choices; and having the system sanction the incorporation of cultural knowledge into practice and policy making.

For more information, contact Marva Benjamin at the CASSP Technical Assistance Center, Georgetown University Child Development Center, 2233 Wisconsin Avenue NW, Suite 215, Washington, DC 20007 or call (202) 338-1831.

Notes . . .

A National Training Institute on "culturally competent" programs will be held in Boulder, Colorado, July 22-26, 1990. The Institute features presentations by staff from programs serving minority children and adolescents. The Institute is sponsored by the Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center, 2233 Wisconsin Ave., NW, Washington, D.C. 20007, (202) 338-1831. (see related article on this page).

The results of a Research Training Institute (RTI) report on the Child and Adolescent Service System Program (CASSP) should be released by the National Institute of Mental Health in May, 1990, according to Dr. Rose Etheridge, research psychologist for RTI. The report will present the findings of an assessment of the activities of the 10 states that received the original CASSP grants.

A report on adolescent health is expected to be released in the fall of 1990 by the U.S. Office of Technology Assessment (OTA), according to Denise Dougherty of OTA. The report will include two separate documents on adolescent mental health services.

Conference Summary: 3rd "System of Care" Research Conference

Left to right: Dr. Bill Buzogany, Mendota Mental Health Institute; Krista Kutash, RTCCMH; Dr. Irving Phillips, Langley Porter Psychiatric Institute; Dr. Al Duchnowski, RTCCMH; and John Clark, Nebraska Department of Education.

Plans for evaluations of large systems of care were presented at the third annual research conference of the Research and Training Center for Children's Mental Health (RTCCMH) of the Florida Mental Health Institute.

The conference, "A System of Care for Children's Mental Health: Building a Research Base," was held February 12 - 14, 1990 in Tampa, FL. More than 260 researchers, policymakers, administrators, clinicians, advocates and parents attended from 37 states and Canada.

Dr. Len Saxe, professor at the Center for Applied Social Sciences in Boston, believes it is time to conduct an experimental test of a children's system of care that would randomly assign children to treatment.

"No one system is universally accepted," said Saxe, who is beginning a national evaluation of the Robert Wood Johnson Foundation's children's projects for multi-agency partnerships to improve services. "We should take all the research strategies and apply them in a systematic and coordinated way."

Dr. Clifford Attkisson, a professor of medical psychology at the University of California's Department of Psychiatry, believes that more fundamental research is needed.

"We are not at a point of comparing one system to another or assigning random services to children," Attkisson said. He is evaluating a plan to replicate California's Children's Demonstration Project of Ventura County in other California counties.

Dr. Len Bickman, of the Center for Mental Health Policy at Vanderbilt University, hopes his evaluation of a system of care for children and adolescents who are military dependents at Ft. Bragg, NC will help discover how a system of care works.

"We are working from the idea that a continuum of care is a more cost effective way of delivering services," Bickman said.

His evaluation, sponsored by the State of North Carolina, will document what the system does right and what is not right, said Dr. Lenore Behar of the North Carolina Department of Human Resources.

The number of minority children suffering from serious emotional disturbances is increasing, said Dr. Freda Cheung, Chief of the Minority Research Resources Branch of the NIMH. Research is needed on the outcomes of minority children treated in community clinics, she said.

Dr. Charles Holzer, of the NIMH funded Center for Cross Cultural Research in Galveston, said minority researchers need incentives to work in public sector mental health facilities.

Thomas Lalley, Chief of the Biometric & Clinical Application Branch of the NIMH, said NIMH is now developing child-focused services research activities. The NIMH budget for the Division of Biometry and Applied Sciences has increased from about $4 million in the early 1980s to $24 million today.

"There are large gaps in the current knowledge and much of what is already known is not being used," Lalley said. "There is a need for expanded research funding, training, and recruitment."

The RTCCMH is preparing a conference proceedings. The proceedings from last year's second annual conference, Children's Mental Health Services and Policy: Building a Research Base, are now available. For more information, write Alissa Algarin at the Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899.

Above Left: *Dr. Robert Friedman, Director, RTCCMH and Beth Stroul, M.Ed., Consultant, CASSP TA Center.*

Above: *Dr. Judith Gardner, Bigel Institute, Brandeis University.*

Left: *Dr. Kerry Hinkle, SC Continuum of Care, answers questions from a participant.*

PROGRAM UPDATE

Treatment Planning

By Michael K. Johnson, Ph.D. and Robert M. Friedman, Ph.D.

Recently, as the emphasis on the development of individualized services for children and their families has increased, there has also grown a recognition of the need for creative and effective treatment plans. Despite its importance, the process of developing such plans has received little attention. The purpose of the present article is to summarize issues and trends in the development of effective treatment plans.

To provide a framework for such a review, the following general definition of treatment planning in children's mental health is offered:

> *Treatment planning is a decision-making process generally undertaken by a group of concerned individuals (both within and outside of the family) with the intent of learning about the strengths, interests, problems, and needs of an individual and his/her family in order to develop a plan of action to enhance functioning.*

This article will first address the participants involved in treatment planning, then the process itself, next the relevant information needed, and then briefly, the plan of action. The article will specifically address treatment planning in group situations.

Participants

Participants in the group treatment planning process typically involve a combination of "standing" members of the committee and attendees who are present because of their interest in a particular child. The standing committee members often involve professionals from different public agencies, including mental health, schools, child welfare, and juvenile justice. They may also include representatives of particular professional disciplines, (such as child psychiatry and psychology), a parent representative, a case manager, and a guardian ad litem. The purpose of having standing members is to insure adequate representation of different perspectives, and to provide a degree of consistency in treatment planning from child to child.

The attendees who are present because of their interest in a particular child may include the child, parents, teachers and other professionals who are familiar with the child, and significant others who play a special role in the child's life, be they extended family, neighbors, clergy, etc.

The involvement of parents, and particularly of children, in group treatment planning meetings, is a relatively new development in the field, and is still far from being widely accepted. In some areas, however, it is considered to be an absolute necessity. Dr. David Fairbanks, Coordinator of one of Florida's SEDNET projects, indicates that "the success of case planning depends on the effective early involvement of parents and the child to ensure that all parts of the system are working with each other and are not at odds."

However, the best approach to involving parents and children is not clear. The step of inviting parents and/or children into a group primarily composed of professionals who they do not know can be frightening and intimidating, and may not result in the development of a productive planning process.

Parents who were surveyed reported widespread dissatisfaction with procedures in which the role of the parent was not clear,

"Too often mental health service providers rush in and feel like they have to 'save' families."
— Glenda Fine

the parent was given limited time to express his/her perspective, and the parent was presented with a new group of people with very little preparation. Glenda Fine, Director of the Parents Involved Network in Philadelphia, emphasized that "it is very important to find out what families want from a case planning team. Too often mental health service providers rush in and feel like they have to 'save' families."

One approach to dealing with this situation involves the use of a "parent advocate" to meet with parents of children prior to the team meeting to help prepare them for the meetings. Lenora Stern and Pat Serra, Coordinator and Assistant Coordinator of Pennsylvania's Child and Adolescent Service System Program (CASSP) report that, "the most successful case planning teams that we have in Pennsylvania began with a parent advocate as a core member of the team. This parent has been able to work with parents and families of children who are referred for services prior to a first meeting with the team thus preparing the parents for the experience of working as peers with professionals."

Also, the importance of proper training for team members is often overlooked. If the goal of the team is to develop an individualized and family-based treatment plan, it is essential that team members understand and accept the philosophy of individualized and family-based services within a community-based system of care.

One approach to training, used in states like Florida and Ohio, involves presenting simulated cases to different committees so that the process of planning can be studied, and comparisons can be made of the plans developed for the same youngster by different committees.

In reflecting on participation in interagency clusters in Ohio, Dr. Susan Ignelzi, former Ohio CASSP director, reports that the clusters worked best when an individual who really knew and liked a child could work with the group and teach the members about the child. "This person was generally one or both of the child's parents, however, it doesn't have to be. As long as the person is able to focus the cluster on the strengths of the child, and

the team can avoid being so deficit-focused, we've found we are much more successful," she said.

Process

In many states, there is a heavy reliance on treatment planning in groups for youngsters with the most serious emotional problems. This approach is based largely on the view that groups of diverse individuals will somehow develop better and more creative plans than individuals.

The most common approach used by the groups is "interactive," in which there is relatively little structure. Instead, the group primarily relies on spontaneous discussion between members to arrive at a decision. After reviewing the early social psychological literature on this type of group, one observer noted that "numerous researchers concur that decision-making with interacting groups inhibits creative thinking" (Van de Ven, 1974).

In particular, Van de Ven indicates that factors that inhibit creative thinking in interactive groups include a reluctance to express ideas that might produce criticism, a tendency to pursue a single train of thought for a long period of time, low participation by many members who feel less competent or of lower status, and a tendency to reach decisions rapidly before all dimensions of a problem have been considered.

In place of interactive groups, Van de Ven makes a case, based on the general research available at that time, for more structured group approaches, such as "nominal" approaches that involve all participants, avoid evaluation of comments during the initial statements, avoid the dominance of group output by a few individuals, encourage the generation and expression of minority opinions, tolerate conflicting ideas, and prevent a premature closure to the process.

A review of Van de Ven's conclusions by Friedman (1989) emphasizes that there has been very little empirical research on group treatment planning, specifically in the human services area, to allow comparative evaluations of the advantages and disadvantages of different approaches, such as interactive and nominal, and techniques like "storyboarding." However, Friedman also notes the importance of carefully considering group process, given the complexity and importance of problems presented to groups and the fact that research evidence suggests that most clinical decision-makers reach judgments rapidly, and utilize only a small amount of the information they have at their disposal (Turner & Kofoed, 1984).

> **"We feel that our local teams truly reflect the unique aspects and needs of each of our communities..."**
>
> **— Sherry Schonberg**

Van de Ven (1974) reports that more high quality ideas emerge during the final one-third of a person's time spent on an issue than during the first two-thirds. Given this, the importance of spending adequate time defining the problem before moving on to the solution, and then adequate time developing a plan, has been emphasized (Friedman, 1989).

Another process issue requiring further study is the population base covered by a standing committee. In Vermont, for example, with a total state population of about 500,000 people, there are 12 separate committees to serve the state. This is consistent with the philosophy of community-based systems of care, ensures relatively ready access to a committee, and is likely to increase the commitment of all individuals to the process. Sherry Schonberg, CASSP coordinator for Vermont, reported that given the dispersion of the population in Vermont combined with the differences in needs and services available between communities, the local planning teams were the only feasible option for the state to adopt. "We feel that our local teams truly reflect the unique aspects and needs of each of our communities, and are much better able to develop therapeutic treatment plans based on a philosophy of individualized services," she said.

Information

In order for effective treatment planning to occur, the members of the committee must have an adequate information base. While such an information base certainly includes the type of data produced by traditional psychological and psychiatric evaluations, and oftentimes other medical examinations, the need for other types of information is being increasingly emphasized if a genuinely individualized plan is to be developed. This includes an emphasis on the strengths and interests of the child and family as well as the problems, an evaluation of practical, functional skills, an understanding of the role of the individual's cultural heritage, an appreciation of the differing views of the situation from the key individuals involved, and an ecological perspective in which the functioning of the child is examined in the context of the total community, family, and educational environment.

"In the Alaska Youth Initiative (AYI), we look at the major life domain areas of vocational/educational/daily structure, behavioral/psychiatric, home/residential, social/recreational, medical, and legal/judicial, and assess the child's strengths and needs in each of these domains," said John VanDenBerg, director of AYI. "The most important thing to remember is that the evaluation and subsequent treatment plan should be need-based as opposed to providing the child or his/her family with a service because it (the service) is available. The plans we develop and the services we offer need to be flexible and dynamic to account for the maturation and changes within a child and his/her environment. If a plan isn't dynamic, at some point it will cease to meet

the needs of the child and family. If we can't meet their needs then we fail them," VanDenBerg said.

Karl Dennis, Director of Chicago's Kaleidoscope program, emphasizes the importance of immediately determining a child's strengths and interests. This provides a foundation upon which to develop a plan. Most clinicians who evaluate and work with children and their families are well trained to identify problems and shortcomings of both the child and his/her family. It is much rarer to find a clinician who routinely identifies strengths of a child and his/her family, and subsequently builds a treatment plan based upon these strengths.

The process of gathering information on all of these domains and from each of the perspectives is complex and often time-consuming. At the Beach Center on Families and Disability at the University of Kansas, a particular focus is placed on strategies for gathering information from family members. A three stage process for case planning is used, the primary aim being to identify strengths of clients with handicapping conditions and their families. The first stage, which is the most critical, is the "story-telling" stage. It is an informal relationship building stage designed to build trust and rapport between families and professionals. "Families have told us on many occasions that paper and pencil evaluations as a means of first contact just don't work," said Rud Turnbull, co-director of the Center. "We've found that families really want to tell their stories to professionals, and when they are allowed to do so, feelings of trust are established. After the storytelling phase, the enrollment process occurs in which we identify all services needed by the child and family and an assessment of strengths and weaknesses takes place." In the third stage the treatment plan is actually carried out. "The ultimate goal of our model is not just to ameliorate problems, but to enhance the identified strengths as much as possible," Turnbull said.

> **"We've found that families really want to tell their stories to professionals, and when they are allowed to do so, feelings of trust are established."**
>
> **— Rud Turnbull**

Dr. Richard Munger of the North Carolina Department of Human Resources has recently compiled instruments to assist in conducting ecological assessments. He emphasizes that when case planners and clinicians begin examining the ecological domains of a child's life during the planning phase of treatment, it broadens their views and allows them to do truly innovative treatment planning. "What we really need to advance the field of ecological evaluation are instruments or tools which are both accessible and easy to use and that get people oriented to this type of thinking. We will never have enough resources to serve all people in all ways that are needed, and strategic decisions are required to determine where to target the limited resources we have at our disposal. Ecological evaluation attempts to identify critical areas in which to intervene that will put a child on a key trajectory toward a life path that will make a difference in their life," he said.

In describing the focus of assessment within the Vermont individualized system model, John Burchard and Richard Clarke (1990) indicate that, "Individualized care necessitates a shift to a more comprehensive, multilevel approach to assessment which examines the social ecology of behavior and attempts to understand children with severely maladjusted behavior by assessing the total environment in which maladjustment occurs." Burchard and Clarke emphasize four levels of assessments: an analysis of the child's and family's strengths and needs; an assessment of the broader social environment in which the child and family live; as assessment of service needs and available community resources; and a plan for the assessment of ongoing concerns and progress.

Interventions

As the emphasis on individualized treatment plans within the context of community-based systems of care increases, the potential interventions grow dramatically. The trend of states to build strong case management services and to maintain a flexible pool of funds to genuinely match the needs of children and families with a treatment plan further increases the diversity of interventions. Changes in Medicaid provisions, as reported here, also increase the opportunity to develop individualized interventions. These interventions will be discussed in greater detail in future articles.

As interventions are implemented, the need for assessment to continue remains strong. The development of "tracking systems" to monitor progress has been a particular focus of the Vermont and Alaska groups (Burchard & Schaefer, 1990; VanDenBerg, 1990), and illustrates the continued interaction of assessment and intervention.

Conclusions

In summary, treatment planning is a vital decision-making process that has received little attention. Unless it is done well, there is little likelihood of developing effective individualized treatment programs. Particular attention needs to be given to such issues as insuring that parents and children are meaningfully involved in the process, developing a group process that generates rather than inhibits originality and reinforces a community-based focus, insuring that the adequate range of information is collected, and developing strategies for monitoring implementation of the treatment plan and subsequent progress by the child.

References for Treatment Planning can be found on page 19.

U.S. House Committee Reports on "Discarded Children"

Services to children in the child welfare, juvenile justice, and mental health systems have been deteriorating and there will be a huge surge in out-of-home placements in the coming decade, according to a report issued in January, 1990 by the Select Committee on Children, Youth and Families, of the U.S. House of Representatives.

In the report, "No Place to Call Home: Discarded Children in America," Congressman George Miller, chair of the committee, wrote "if current trends continue — and they most likely will — the number of children living in foster homes, hospitals, and detention facilities may jump from nearly half a million right now to more than 840,000 by the year 1995."

"There has been a massive failure at all levels of government in enforcing the laws that were supposed to provide needy children with services and protection," he said.

The committee prepared the report to see if legislation made 10 years ago to support children in troubled families was succeeding.

Miller found that social and economic conditions are hurting large numbers of American families in ways that our current child welfare, mental health and juvenile justice systems were not created to meet. The report found extraordinary failings in these systems that are in the system's capacity to control and that too many of the services which exist are uncoordinated, inefficient, and ultimately ineffective, as administrators themselves attest, Miller wrote.

The report compiles expert testimony, parent's and children's personal reports, new survey data collected by the committee, and recent independent, university, foundation, and government sponsored research.

The report found that: preventive services are rarely available for troubled families in need of support; case-loads are escalating rapidly for frontline workers; and few workers, including foster parents, receive the training they need.

Children are being driven into out-of-home services because of child abuse, homelessness and new conditions from crack cocaine and alcohol abuse, Miller said.

"The net result is that more children are harmed by the system that is designed to protect them, and more kids are separated from their families while only minimal efforts are being made to strengthen their families," he said.

According to the report, the experience in each out-of-home placement system is similar. Children fail to receive counseling and safeguards that would enable them to return home or find permanent families. Their families are denied the essential services necessary to help them retain or be reunited with their children.

National foster care rolls grew an estimated 23 percent between 1985 and 1988, the report shows. Despite an initial decrease from 1980 to 1985 the number of children in foster care rose from 303,500 in 1980 to 340,300 in 1988. The report projects that number will increase to 553,600 by 1995.

The number of youth in public and private juvenile correctional facilities increased 27 percent from 1979 to 1987. Despite a decrease from 1975 to 1979 the number of children in custody rose from 74,270 in 1975 to 91,646 in 1987. The report projects that number will increase to 119,700 by 1995.

In the mental health system, there was a 60 percent increase in the number of children as inpatients in hospitals or residential care between 1983 and 1986. The number of children in residential care rose from 34,068 in 1983 to 54,716 in 1986. At the same time, an estimated 70-80 percent of children with emotional disturbances received inappropriate services or no services at all.

While the number of children in out-of-home placements has increased over the last few years, funding for the programs that serve these children has not kept pace, according to the report.

Funding for child welfare services has not yet reached the 1980 authorized level of $266 million. The funding for the foster care program has grown from $163.5 million in 1981 to $246.7 in 1989, less than a 10 percent real increase in 1981 constant dollars.

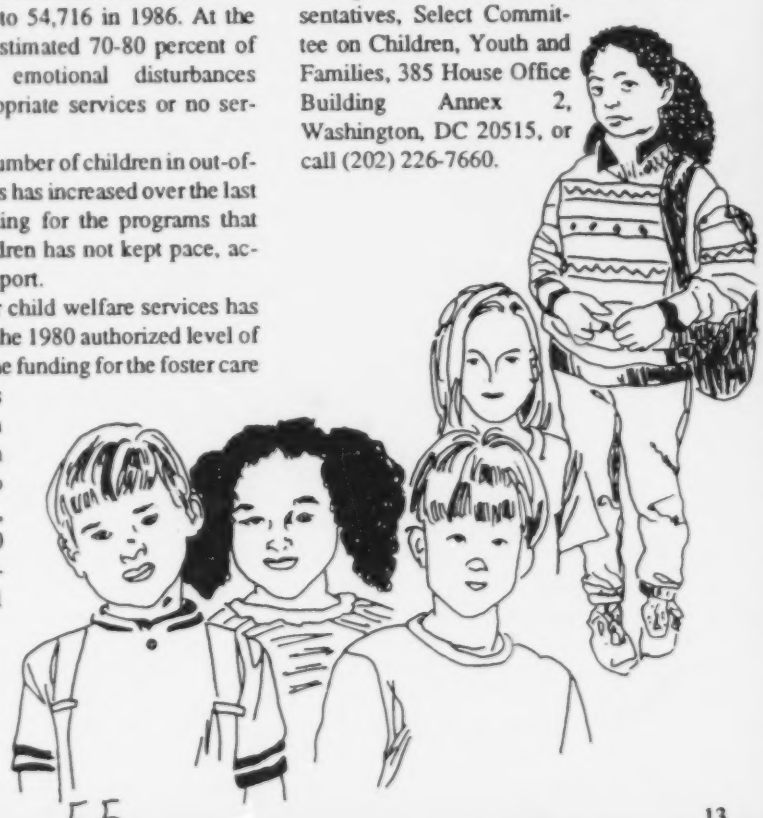
Funding for the Juvenile Justice and Delinquency Prevention Act has declined from $109.2 million in 1981 to less than $70 million in 1989, a real decrease of more than 55 percent.

Funding for the Alcohol, Drug Abuse and Mental Health Program has dropped from $519 million in 1981 to $502.7 million in 1989, a real decrease of 30 percent.

The report concludes that "family preservation programs" which provide intensive family-based services can prevent unnecessary removal of children from their families. But these programs are far too limited in number and extent.

"We have failed to address the problems of the 1980s that have devastated millions of children and their families," said Miller. "In fact, decisions by government in the areas of family services, health care, housing, and drug policy have compounded the crises. Unless we take action, far more children with more complex problems will be in care in the 1990s at a far greater cost and with a completely unprepared children's service system." Miller said. "And in the 2000s, those children will be on the streets, on the welfare rolls and in the jails."

For more information or for a copy of the report contact the U.S. House of Representatives, Select Committee on Children, Youth and Families, 385 House Office Building Annex 2, Washington, DC 20515, or call (202) 226-7660.



55

CROSS COUNTRY UPDATE

ALABAMA

Two new programs intended to fill gaps in the service system have opened. In an interagency effort to better serve children and adolescents, both programs are jointly funded by the Alabama Department of Mental Health and Mental Retardation and the Alabama Department of Human Resources.

A new intensive residential treatment program opened at Glenwood Mental Health Services in Birmingham to serve 8 children with severe emotional disturbances ages 6 to 12. Currently, the Hickory House program in Mobile is the only intensive residential treatment program providing services to this population. The new program is more accessible to the northern part of the state.

A ten bed Short-Term Treatment and Evaluation Program (STTEP) is available at the Brewer-Porch Children's Center in Tuscaloosa. STTEP will offer comprehensive diagnostic and evaluation services, and short-term (7 to 90 days) residential treatment to children with serious emotional disturbances.

COLORADO

Colorado kicked off its newly funded CASSP project with a meeting of the Child and Adolescent Mental Health Planning Council on November 28, 1989. The Council, which will advise the Division of Mental Health on the implementation of CASSP, consists of representatives from a broad spectrum of state and local agencies and organizations that serve children.

The Council meeting began with an address by Dr. Jane Knitzer, on mental health services for children and adolescents. Dr. Knitzer's talk was followed by a panel discussion of collaborative program efforts in Colorado, including a multi-purpose interagency initiative in Colorado Springs/El Paso County, parent-professional cooperation and training on the Western slope, and a family and adolescent crisis team jointly sponsored by the mental health center and social service department in Jefferson County. The meeting also included a review of the CASSP workplan.

DELAWARE

Children's mental health in Delaware may be uniquely organized: the Division of Child Mental Health Services resides in a separate cabinet level Department of Services for Children, Youth and Their Families. Recently:

Brandywine Project, an intensive family-centered, home and community-based project, became operational and will be reproduced downstate.

Three day treatment programs have opened: a program for young children 3-6 who have survived abuse, neglect, and other severe trauma; a day treatment program for children 6-12; and for adolescents, a community-based ethnically sensitive model in the inner city.

The able leadership of Roberta Ray, Ph.D. resulted in a Mental Health Systems Improvement Project (MHSIP) grant from NIMH.

Finally, Delaware's model of managed care is operational. It takes a team approach to planning and monitoring, and eliminates tensions between clinician and clinical coordinator/case manager.

WASHINGTON, DC

One of the principle objectives of the District's CASSP initiative is the establishment of an active family support group. The Family Advocacy and Support Association (FASA) was founded in 1987, under the auspices of the Child/Youth Services Administration (CYSA), to support families of children with serious emotional disturbances. CYSA provides parents with information and resources. Presently, CYSA has pledged $10,000 in a contract to support the ongoing activities of FASA.

GEORGIA

The SE Georgia local CASSP demonstration project has been approved for the fourth and fifth years of its 5 year CASSP grant. The project, operated by a 24 county interagency consortium (The Southeast Regional Troubled Children's Committee, Inc.) will implement the Training and Family Support Network.

CASSP will develop and support local programs and organizations for parents and caretakers of troubled children. In addition, it will develop a regional interagency agenda addressing the needs of troubled homeless children and troubled children at risk of becoming homeless. An ongoing emphasis will be on providing expert training programs for all area professionals, parents, and others concerned about services to troubled children.

IDAHO

Idaho CASSP has been in the Division of Family and Children's Services (FACS), with the CASSP Director reporting to the FACS Division Administrator. In July 1989, fiscal and staff resources for children's mental health services programming were transferred from the community mental health centers to FACS centers statewide. FACS administers these services along with all child welfare, youth rehabilitation, and adolescent substance abuse services and all privately contracted and institutional child and adolescent treatment programs statewide.

The Idaho CASSP staff have provided extensive regional training related to this transition of children's mental health services.

Marilyn Sword of the Idaho CASSP staff chaired a Parent Task Force meeting to design a parent information packet for the parents of any child placed in an intensive treatment facility statewide. This includes mailings to parents of children placed in day treatment and treatment family programs; intensive residential, secure treatment and psychiatric treatment programs. Technical assistance was provided by Barbara Friesen of the Portland State University Research and Training Center.

In September, 1989, CASSP co-sponsored a collaborative, statewide conference with the Mental Health Advisory Council, the Community Mental Health Centers, and FACS, which included an all day workshop by Karl Dennis and Naomi Tannen on in-home treatment and therapeutic foster treatment approaches.

Also in September, technical assistance and training and a review were provided to the Migrant Head Start Program by Josie

Romero, LCSW, of Alexian Associates in San Jose, Califomia.

The Idaho Network for Children and Idaho CASSP distributed to foster parents narrative summaries from their collaborative survey of foster parents.

KANSAS

In 1989, using CASSP funds, Mental Health and Retardation Services (MH&RS) within the Department of Social and Rehabilitation Services entered into a contract with the Department of Psychology at Wichita State University to provide training for providers of Home-based Family Services. That training is complete and has resulted in video tapes of the training sessions, an outline for a manual on developing home-based intervention programs, an outline for a training manual for home-based therapists, and proposed standards for home-based services. Those standards are being reviewed prior to their adoption.

Also in 1989, MH&RS entered a contract with the School of Social Welfare at the University of Kansas to provide training for children and adolescent case managers and their supervisors. That training is complete, and follow-up sessions are scheduled. A training manual is a product of that contract also.

A parents manual for families of children with an emotional disability in the individualized educational plan (IEP) has been developed by the School of Social Welfare through a contract with MH&RS. Standards for children and adolescent case management services have been developed and will be adopted in the near future. These standards were developed collaboratively with community mental health centers, family advocates, schools, and MH&RS. Finally, another contract has been developed with the school by MH&RS to conduct a comprehensive policy analysis of the state's mental health system for children and adolescents.

KENTUCKY

Creasa C. Reed, parent consultant for Kentucky's CASSP, was recently elected secretary of the Federation of Families for Children's Mental Health.

The Kentucky Coalition for People with Handicaps, Inc. was recently awarded a grant from the Portland State University Research and Training Center for a parent coordinator. The parent coordinator attended an orientation in Portland.

Kentucky and Ohio CASSP co-hosted the First National Respite Conference in conjunction with the Center. There were more than 170 registrants from all over the United States. Participants attended a variety of workshops and met with state delegations to discuss the development of respite programs in their respective states. Each state presented their plan at the closing luncheon.

LOUISIANA

Louisiana's Coordinating Council for Children and Families has signed the first statewide CASSP Plan and the accompanying Collaborative Budget Agreement. The plan assures coordinated policy development, comprehensive planning, and collaborative budgeting among the various departments and state and local agencies that serve children with emotional disturbances and their families. It includes activities for implementation of Louisiana's CASSP goals. An interagency budget request for Fiscal Year '90-'91, submitted by the Governor's Office, includes funding for next year's CASSP activities and continuation of CASSP staff when the NIMH grant ends.

CASSP has worked closely with the Division of Mental Health to develop Louisiana's Three Year Mental Health State Plan. The Plan represents over $32 million in increased services for children and adolescents with emotional disturbances. The primary source for funding is expansion of both the Targeted Case Management and Psychosocial Rehabilitation options under Medicaid. The Mental Health Plan is closely interrelated with the CASSP Plan.

MARYLAND

Maryland CASSP and a number of other interagency initiatives have been transferred to the Governor's Office for Children, Youth, and Families. These interagency efforts will be supervised and coordinated by the Governor's Special Secretary and the Subcabinet for Children, Youth and Families. Pilot projects to create local governing entities to return children from out of state, and to prevent out-of-home placements through early intervention are expected to commence during the next fiscal year.

CASSP recently co-sponsored a conference on system response to the needs of homeless children and youth. Efforts were coordinated with all in-state service providers. Maryland participated in a federal-level strategy session to increase coordination between NIMH and the Administration for Children, Youth and Families.

MINNESOTA

With the 1989 passage of the Children's Comprehensive Mental Health Act, Minnesota is busy developing the services and coordination mechanisms mandated. Local advisory councils and local coordinating councils are currently mandated to be in all 87 Minnesota counties. Service implementation dates are spread out until January 1, 1992. Case management, to be implemented by July 1, 1992, will likely be the most significant new service. It will provide advocacy and coordination across systems for the child and the family.

Currently, eight Minnesota counties are receiving project dollars to demonstrate how the requirements of the legislation can be implemented at the local level. These projects feature a "customized" nature. Both services and interagency coordination are adapted to address the population they are serving. These projects will be funded through October 1991, when county dollars will continue the efforts.

MISSISSIPPI

The goal of the Mississippi CASSP Community Level Case Management Project is to demonstrate for three years the capacity of a coordinated case management system to enhance interagency cooperation on a continuing basis, and to produce cost savings while providing quality case management services.

Local case managers are providing services at the community level which center around developing individualized service

CROSS COUNTRY UPDATE

plans for the entire family. Since September, community level case managers have received over 15 referrals. The Local Case Manager assigned to work with the Division of Children and Youth residential programs has developed follow-up and aftercare plans for over 40 clients exiting the Division's residential programs.

CASSP staff are increasing awareness of service needs of children with SED by providing in-service training and technical assistance. CASSP staff participate in Case Staffing and Interagency Councils to develop a comprehensive service plan for clients.

NORTH CAROLINA

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services recently awarded a contract to the North Carolina Alliance for the Mentally Ill to develop a statewide network of families with children who have serious emotional problems. Over the next year the Alliance will be developing self-help groups, providing training, and expanding the NC AMI library to include additional materials which specifically are relevant for parents of children who have serious emotional problems.

OHIO

In 1989, the Ohio Department of Mental Health began a statewide certification process for children with serious emotional disturbances after a pilot study was conducted by the department. A three part process is used, including DSM-III-R diagnosis, duration of impairment, and Children's Global Assessment Scale, to determine if a youth is certified as SED. Duration of impairment is directly related to the CGAS score during the first twelve months of impairment.

Of over ten thousand youth statewide, 62 percent of those submitted have been certified as SED during the first six months. Thirty-three percent are female and 67 percent are male. Data are being collected on type of agency providing services, race, educational program, other service providers, current living situation, and other disabilities. Preliminary results show that youth with SED are more likely to be in special school programs, receive services in other systems, and have other disabilities. The purpose of certification of youth as SED is to provide aggregate data for funding and programming purposes, and to access the needs of youth with SED in Ohio.

SOUTH CAROLINA

The South Carolina CASSP initiative focuses on the relationship between mental health and juvenile justice systems in Greenville County, South Carolina, a mixed urban-suburban-rural area with a substantial African/American population. The project is to facilitate coordination between the systems and to serve youth with serious emotional disturbances in the juvenile justice system. SC CASSP plans to expand the project throughout the state during the next several years.

In brief, the CASSP initiative includes three components. Locally, efforts are directed toward developing a more effective system of service delivery, coordinate cases that the agencies have in common, and plan services collaboratively.

Service provision has been an important component of the designed systems change. Family Preservation, intensive services provided to the family in the home, is focused on those "deep-end" children of the juvenile justice and child mental health systems. Services include parent support, self-esteem building, parent skills training, school stabilization, crisis intervention, individual and family therapy, and assessment and referral. The focus of this intervention is to prevent further out-of-home placement and further contact with the court. In a Youth Diversion Project, trained and supervised college students spend several hours each week advocating for the youth, tutoring, and providing a good role model to the offender. This project has favorable results and has received enthusiastic support from both the juvenile justice system and the Department of Mental Health.

TEXAS

The Texas Department of Mental Health and Mental Retardation and the Texas Juvenile Probation Commission are jointly funding a community-based system of care for youth with severe emotional disturbances referred through the juvenile justice system. Five demonstration sites have been selected, four through Mental Health and Mental Retardation Centers and one through the Juvenile Probation Commission. The sites' executive directors met with program sponsors April 19, 1990 to discuss plans and begin the programs. This project is one of five programs funded statewide through a $2 million appropriation for mental health services.

The Texas Alliance for the Mentally Ill plans to begin ten child-adolescent network groups throughout the state during the next 18 months through a CASSP grant. The Mental Health Association of Texas recently published a report, "Do Kids Count?," outlining system needs in the state, and is developing statewide public awareness, legislative liaison, and family advocacy.

WASHINGTON

Washington CASSP has proposed to implement an effort that will enhance and expand services available to homeless youth with emphasis on providing shelter and services that respond to the mental health needs of this population. The Mental Health Department has allocated $70,000 for promoting the mental health component of this multi-system effort.

The CASSP philosophical approach is to develop services that respond to the needs of homeless adolescents, provide for their immediate needs, help maintain their health and facilitate in the making of available choices. CASSP will utilize its experience with fostering collaborative approaches and will involve a unique coalition of agencies in planning and implementation of the proposed enhancements.

Washington state is implementing significant reform in its mental health system due to legislation passed in April 1989 providing $24 million for community implementation. The legislation encourages the development of county-based and county-managed services with adequate local flexibility to assure eligible people have access to the least restrictive treatment alternative appropriate to their needs, and the availability of treatment components to assure continuity of care. Children and other underserved populations were included in

the bill; however, most counties put an emphasis on services for adults.

The legislation promotes a greater range of service in the commmunity, with an emphasis on housing options and case management. This push away from clinic-based programs is consistent with the Washington CASSP effort to promote individualized services that serve children in their own communities and in their own families whenever possible.

Washington CASSP has initiated a project that will integrate mental health services for mentally ill homeless youth with homeless and runaway services. The targeted population includes youth who have "failed" other treatment alternatives or who have been terminated from treatment. This will be a relatively small demonstration in Seattle/King County.

The 1989 collaboration between mental health and education has funded two service management teams, three new day treatment programs, three day treatment expansions and two rural service models.

Our seven demonstration sites are providing coordinated services to children considered the "hardest to treat." Referrals are screened by an interagency committee of administrators. Children's case managment staff provide an indepth assessment of the child's and family's needs and strengths, then create an interagency/family treatment team. Crisis situations are anticipated and a flexible wraparound fund is available for individualizing services. Family members are actively involved from the point of initial referral and screening throughout the entire treatment/education process.

WEST VIRGINIA

West Virginia is in the process of a government reorganization. The former Department of Health, which was the home for Children's Mental Health, is now the Department of Health and Human Resources. The merging of these two agencies is expected to create smoother communication and an increased collaborative strategy for service delivery to children with SED statewide.

Governor Gaston Caperton, who is attempting to consolidate government and incease fiscal efficiency, has made children a priority and has commissioned a task force to study the needs and make recommendations.

STATE CONTACTS:

Charles L. Day
Coordinator-CASSP
Department of MH/MR
200 Interstate Park Drive
PO Box 3710
Montgomery, AL 36193-5001

William Bane
Child/Adolescent Program Specialist
Division of Mental Health
3520 W Oxford Avenue
Denver, CO 80236
(303) 762-4076

Julian Taplin
Director
Division of Child MH Services
Department of Services for Children, Youth and Families
Delaware Youth & Family Center
Centre & Faulkland Roads
Wilmington, DE 19805-1195
(302) 633-2600

Gail Saunders
CASSP Coordinator
Child/Youth Svcs Administration
1120 19th Street, NW, Suite 700
Washington, DC 20036

Steven Tanner
Project Director
Southeast Regional Troubled Children's Committee (SERTCC)
516 Drayton Street, 4th Floor
Savannah, GA 31401
(912) 234-0130

Jody Lubrecht, Ph.D.
CASSP Director
Div. of Family & Children's Svcs
Dept. of Health and Welfare
450 West State Street
Boise, ID 83720
(208) 334-5520

Randolph Proctor
Director of Children and Adolescents Services
Dept. of Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison
Topeka, KS 66612
(913) 296-3271

CASSP Director
Dept. of MH/MR
Division of Mental Health
275 East Main Street
Frankfurt, KY 40621
(502) 564-7610

Elizabeth Sumrall
CASSP Parent Coordinator
Office of Mental Health
PO Box 4049
Baton Rouge, LA 70821
(504) 342-2540

Tom Merrick
CASSP Project Coordinator
Mental Hygiene Administration
Div. of Child/Adolescent Services
201 West Preston Street, 4th Floor
Baltimore, MD 21201
(301) 225-6649

Joan Sykora
Director, Child/Adolescent Svcs
Mental Illness Program Division
Dept. of Human Services
Centennial Office Bldg.
658 Cedar Street, 4th Floor
St. Paul, MN 55155
(612) 296-7905

Tumutual B. Norton
CASSP Project Coordinator
Dept. of Mental Health
Division of Children and Youth Services
1101 Robert E. Lee Bldg
239 North Lamar Street
Jackson, MS 39201
(601) 359-1288

Scott Bryant-Comstock
Chief of Family Services
NC Dept. of Human Resources
Division of MH/MR/SAS
325 North Salisbury Street
Raleigh, NC 27611

Sarah-Jane Workman
Dept. of Mental Health
30 East Broad Street, 11th Floor
Columbus, OH 43215
(614) 466-1984

Jerome H. Hanley, Ph.D.
Director
Division of Children, Adolescents and Their Families
SC Dept. of Mental Health
Box 485
2414 Bull Street
Columbia, SC 29202
(803) 734-7766

Gerry M. McKinney, MSW
CASSP Program Director
Dept. of MH/MR
PO Box 12668
Austin, TX 78711-2668
(512) 465-3761

Richard E. Westgard, MSW
CASSP Project Director
Dept. of Social & Health Services
Mental Health Division
Mailstop: OB-42F
Olympia, WA 98504
(206) 586-3775

David Majic
CASSP Coordinator
Dept of Health & Human Services
Division of Health
1900 Kanawha Blvd, East
Charleston, WV 25305

RESOURCES UPDATE

Research and Training Center for Children's Mental Health

The Research and Training Center for Children's Mental Health (RTCCMH) of the Florida Mental Health Institute is funded by the National Institute on Disability and Rehabilitation Research and the National Institute of Mental Health. The RTCCMH mission is to improve services for children with serious emotional disturbances and their families by increasing the knowledge base for such services. As part of its commitment to this mission, RTCCMH provides a variety of training, consultation, and dissemination activities.

An annotated bibliography describing materials prepared by RTCCMH staff is available upon request. Copies of material or further information can be obtained from Dr. Al Duchnowski, Director of Training, Consultation and Dissemination, RTCCMH, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899 (813) 974-4500.

New products available from RTCCMH include:

—2nd Annual Conference Proceedings. Children's Mental Health Services and Policy: Building A Research Base, February, 1989.

—Conference Proceedings. Mental Health and Education: Partners in Serving Emotionally Disturbed Children. May, 1988.

—Psychiatric Hospitalization of Children and Adolescents: Testimony to the HRS Committee, Florida Senate. February, 1990.

—#550 Children's Mental Health: Challenges for the 90s. In The Journal of Mental Health Administration, 17(1), Spring, 1990.

—#551 Examining The Research Base for Child Mental Health Services. Also available in The Journal of Mental Health Administration, 17(1), Spring, 1990.

—#202 The Epidemiology of Childhood Psychiatric Disorders: Prevalence Findings From Recent Studies. In the Journal of the American Academy of Child and Adolescent Psychiatry, 29(1), January, 1990.

This newsletter is prepared by RTCCMH staff to provide information about developments in services for children with serious emotional disturbances and their families. We invite you to reproduce the material and distribute the information in any way you wish for the purpose of increasing knowledge about the needs and services in children's mental health.

We ask you to acknowledge the source, and let us know how you used it.

Thanks!

Screening Guidelines

The Task Force on Screening and Assessment of the National Early Childhood Technical Assistance System has released guidelines for the identification and assessment of children who should participate in programs related to the infant-toddler (Part H) and the preschool (Part B, Section 619) components of P.L. 99-457, the Education for the Handicapped Act Amendments of 1986.

To order a copy of "Screening and Assessment: Guidelines for Identifying Young Disabled and Developmentally Vulnerable Children and Their Families," contact the National Center for Clinical Infant Programs, 2000 14th Street North, Suite 380, Arlington, VA 22201-2500 or call (703) 528-4300. A single copy costs $11.20.

AIDS Education

The National Rural and Small Schools Consortium (NRSSC) has prepared a manual on how to approach HIV/AIDS education in rural communities. The "What Works? HIV/AIDS Education in Rural America" manual is based on a 1989 study of rural and small school districts which have found effective strategies to develop HIV/AIDS education programs in conservative rural communities. The manual costs $10.50 and is available from the NRSSC, National Rural Development Institute, Western Washington University, Bellingham, WA 98255, (206) 676-3576. The NRSSC also has "A Resource Guide to Effective HIV Education in America's Rural Schools" at $10.50.

Community-based services

A three volume series on community-based service approaches is available from the CASSP Technical Assistance Center at the Georgetown University Child Development Center. The documents are products of a recently completed national study and describe home-based services, crisis services and therapeutic foster care respectively.

Single volumes are available at $10; the volume series price is $25. Contact Mary Deacon, CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road NW, Washington DC 20007, (202) 687-7537.

Supported Employment

Critical issues in implementing supported employment projects are presented in "Special Report: An Examination of The Impact of Supported Employment on Our Nation's Citizens with Severe Disabilities." The report, published by the president's committee, includes recommendations on starting or improving supported employment programs.

Copies of the report are available at no charge by contacting the President's Committee on Employment of People with Disabilities, Suite 636, 1111 20th Street, NW, Washington, DC 20036-3470, (202) 653-5044 or (202) 653-5050 TDD.

Hispanic Students

"Exceptional Children," the official journal of The Council for Exceptional Children, has published a special edition which focuses on meeting the multicultural needs of Hispanic Students in Special Education.

For a copy of the October, 1989 issue of "Exceptional Children," write Editor-Designate of Exceptional Children: Dr.

60

Naomi Zigmond, Professor of Special Education, University of Pittsburgh, 5R23 Forbes Quadrangle, Pittsburgh, PA 15260.

Disability in the US

The National Institute on Disability and Rehabilitation Research has produced a Chartbook on Disability in the United States for the U.S. Department of Education.

The book has statistical information on the prevalence of disabilities, characteristics of people with disabilities, causes of disabilities, disability and the elderly and children, and work and disabilities. The information is generalized data from national survey and program data.

To receive a copy of the book contact the U.S. Department of Education, Washington, DC 20202-2646.

Network on Disabilities

The National Center for Youth with Disabilities has developed a computerized network for youth-related information regarding current research and literature, legislation and public policy, model programs and projects, consultants available to serve technical assistance functions for programs, and training or education materials relevant to adolescence.

For more information on the Center or the network, write the National Center for Youth with Disabilities, Adolescent Health Program, University of Minnesota, Box 721 UMHC, Harvard Street at East River Road, Minneapolis, MN 55455 or call 1-800-333-NCYD or (612) 626-2825.

NC Adoption Project

An analysis of post-service evaluation instruments is being completed by the North Carolina Adoption Project. The project, funded under the Adoption Opportunities Act by the Children's Bureau, Washington, D.C., has developed a service delivery system to meet the pre- and post-placement needs of families who adopt children with special needs. Data have been collected from 150 families in four demonstration and control sites.

For more information on the project, write the North Carolina Department of Human Resources Division of Mental Health, Mental Retardation, and Substance Abuse Services, 325 North Salisbury Street, Raleigh, NC 27611 or call (919) 733-0598.

Rural Service Delivery

"The Rural Special Education Quarterly," the official journal of the American Council on Rural Special Education (ACRES), has recently produced two special issues oriented toward effective service delivery strategies for rural areas. The RSEQ Vol. 9, #4 issue addresses the use of advanced technologies in serving rural students with disabilities, and in providing management, inservice and preservice assistance. The RSEQ Vol. 10, #1 issue concerns services to "at-risk" students, including those with disabilities, alcohol and/or drug problems, suicide attempts/low self-esteem, dysfunctional families, illiteracy, or those who are migrant, minority and/or poor.

The cost of each issue is $8. For more information contact "Rural Special Education Quarterly," American Council on Rural Special Education, Western Washington University, Miller Hall 359, Bellingham, WA 98225 or call (206) 676-3576.

Special Issue

"Administration and Policy in Mental Health" will publish a special issue on children's mental health in Sept/Oct 1991. Manuscripts should be no more than 20 double-spaced pages, including references and a 100 word abstract, should be prepared in American Psychological Association style, and must be received by February 1, 1991.

For more information, or to submit a manuscript, contact Lenore Behar, Ph.D. or Richard Munger, Ph.D., North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, 325 N. Salisbury St., Raleigh, NC 27611 (919) 733-0598.

Professional and Parent Resource Center

The Professional and Parent Resource Center Child and Family Services Branch, of the Department of Human Resources of North Carolina would like to announce the availability of a number of guidebooks and papers for a nominal cost. To order a bibliography, contact the Professional and Parent Resource Center, 3132 Roxboro Rd., Durham, NC 27704.

Treatment Planning References and Resources

Alaska Youth Initiative information available from: John VanDenBerg, Coordinator, Child and Adolescent Mental Health; Alaska Dept. of Health and Social Services; Division of Mental Health and Developmental Disabilities; P.O. Box HO4; Juneau, AK 99811-0620.

Beach Center on Families and Disability information available from: Rud Turnbull, Ph.D., Co-director; Beach Center on Families and Disability; University of Kansas; Lawrence, KS 66015.

Burchard, J.D., & Clark, R.T. (1990). The role of individualized care in a service delivery system for children and adolescents with severely maladjusted behavior. Journal of Mental Health Administration, 17(1), 48-60.

Ecological Evaluation information available from: Richard Munger, Ph.D.; North Carolina Dept. of Human Resources; Division of MH/DD/SAS; 325 N. Salisbury St.; Raleigh, NC 27611.

Friedman, R.M. (August, 1989). Creativity in Group Decision-Making. Paper presented at "Back to the Future: A training workshop on multi-problem kids"; Orlando, FL.

Kaleidoscope information available from: Karl W. Dennis, Executive Director; Kaleidoscope - Chicago; 1279 N. Milwaukee, Suite 250; Chicago, IL 60622.

Parent Involved Network information available from: Glenda Fine, Mental Health Association of Southeast Pennsylvania; Parent Involved Network; 311 S. Juniper St., Philadelphia, PA 19107.

Pennsylvania CASSP information available from: Lenora Stern, CASSP Coordinator; or Pat Serra, Assistant CASSP Coordinator; Pennsylvania Office of Mental Health, 309 Health and Welfare Bldg., Harrisburg, PA 17120.

SEDNET information available from: David Fairbanks, Ph.D.; SED Network District IIB; 1940 N. Monroe St., Suite 50; Tallahassee, FL 32303.

Susan Ignelzi, Ph.D. can be contacted at: RD#1, Box 37; Henryville, PA 18332.

Turner, J.A., & Kofoed, L. (1984). Decision-making, professional discipline, and program affiliation: Selection of an inpatient treatment alternative. Journal of Clinical Psychology, 40(3), 858-865.

Tracking System Information presented at the Third Annual Conference A System of Care for Children's Mental Health: Building a Research Base, February, 1990, Tampa, FL. For more information contact: John Burchard, Ph.D., or Mark Schaefer; Department of Psychology; University of Vermont; John Dewey Hall; Burlington, VT 05403. Or: John VanDenBerg, address above.

Van de Ven, A.H. (1974). Group Decision-Making and Effectiveness: An Experimental Study. Kent State University Press, Kent, OH.

Vermont CASSP information available from: Sherry Schonberg, CASSP Coordinator; Department of Mental Health; 103 S. Main St.; Waterbury, VT 05676.

Special Publications Released on Children's Mental Health

Two recent publications, edited by staff of RTCCMH, highlight both the progress that has been made in serving children with serious emotional disorders and their families, and the problems that remain.

Advocacy on Behalf of Children with Serious Emotional Problems, is edited by Robert M. Friedman, Albert J. Duchnowski, and Elissa L. Henderson, and was published in September, 1989 by Charles C. Thomas, Publisher. According to the editors, the book is intended "to be a tribute to the tremendous efforts and enormous contribution of advocates, both from within the system and outside of the system," and to highlight the need for partnerships between researchers and advocates.

The book's 12 chapters explore advocacy from a variety of perspectives. Forewords are provided by Marian Wright Edelman of the Children's Defense Fund, and Rep. George Miller, Chair of the Select Committee on Children, Youth, and Families of the U.S. House of Representatives.

The second publication, edited by Friedman and Duchnowski, is a special Spring, 1990, issue of The Journal of Mental Health Administration on "Children's Mental Health Services." This special issue includes 11 articles discussing such topics as innovative service delivery models, approaches to planning and service organization, and the role of parents in service planning and service system development.

The issue begins with an article by Duchnowski and Friedman that addresses seven major challenges for the children's mental health field in the nineties. These challenges relate to training and human resources development, funding for services, research, interagency collaboration, overall service system development, advocacy, and children at-risk for developing serious emotional disorders.

Copies of the book on advocacy may be purchased from Charles C. Thomas, 2600 South First St., Springfield, IL 62794-9265, for $29.75. Copies of the special journal may be purchased from Dr. Bruce Levin, Editor, The Journal of Mental Health Administration, Florida Mental Health Institute, 13301 N. 30th St., Tampa, FL. 33612, for $7.50 each.

4th Annual Research Conference Planned

Keep in touch with the latest research on children's mental health services. The Research and Training Center for Children's Mental Health will hold the 4th annual research conference, "A System of Care for Children's Mental Health: Expanding the Research Base," on February 18-20, 1991 in Tampa, Florida at the Wyndham Harbour Island Hotel.

The Center is accepting suggestions for sessions and abstracts for the conference. If you are interested in presenting either a paper or poster send a 300 word abstract to the Research and Training Center by October 1, 1990 to Dr. Al Duchnowski, Director of Training, Consultation and Dissemination, Research and Training Center for Children's Mental Health, Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899 or call (813) 974-4500. Watch for more information in future mailings.

UPDATE

Research and Training Center for Children's Mental Health
Florida Mental Health Institute
13301 Bruce B. Downs Blvd.
Tampa, Florida 33612-3899
813/974-4500

Non-Profit Org.
U.S. POSTAGE PAID
at Tampa, Florida
Permit No. 257

Forwarding and Address Correction Requested

Events,activities, programs, and facilities of the University of South Florida are available to all without regard to race, color, sex, religion, national origin, Vietnam or disabled veteran status, handicap, or age, as provided by law and in accordance with the University's respect for personal dignity.

This public document was promulgated at an annual cost of $20,560 or $.51 per copy including preparation, printing, and distribution, to provide information about mental health services for children and the activities of the Research and Training Center for Children's Mental Health, FMHI, USF. [90-19]

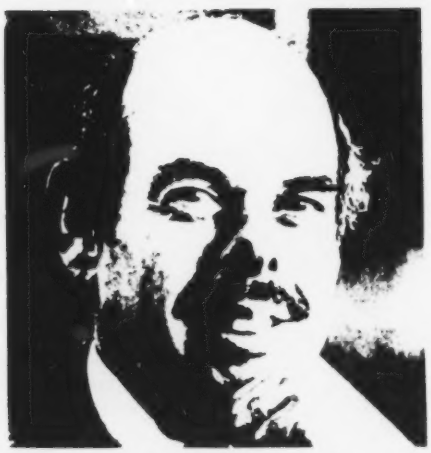
Florida Mental Health Institute, University of South Florida, Tampa, Florida

UPDATE

Improving Mental Health Services for Children and Their Families

VOLUME 7, NUMBER 1 SUMMER 1991

Children's Mental Health Bills Introduced in Congress



Rep. Henry Waxman, Chair of the House Subcommittee on Health and the Environment

Several bills have been introduced into Congress which would provide competitive grants to states to improve services for children's mental health.

An omnibus mental health bill to improve community mental health services has been introduced by Representative Henry Waxman of California, Chair of the House Subcommittee on Health and the Environment. The children's component of this bill, H.R. 2311, would replace a children's mental health bill, H.R. 1197, which had been introduced earlier by Representative George Miller of California.

Both bills would provide five-year grants for states, on a competitive basis, to implement community-based, multi-agency systems of care for children with emotional disorders and their families. The programs are to implement the philosophy and model of a system of care developed through the efforts of the Child and Adolescent Service System Program of the National Institute of Mental Health. $100 million would be provided for the first year of grants.

In addition, Waxman's bill, H.R. 2311, would renew $270 million in Alcohol, Drug Abuse and Mental Health Administration block grants to states for community mental health services. The money would fund community mental health services for adults and would provide a 10% set-aside for children with serious emotional disturbances.

The bill has been voted on favorably by Waxman's subcomittee and is progressing through the House, according to Elaine Viccora of the National Mental Health Association (NMHA).

In the Senate, a children's mental health bill introduced by Senator Edward Kennedy of Massachusetts, S. 924, became part of a larger omnibus mental health bill, S. 1306. Kennedy's bill would have grants administered through the Alcohol, Drug Abuse and Mental Health Services Administration instead of the National Institute of Mental Health as in the House bills.

It would place more emphasis on special education and would require states to contribute an increasing amount of funding for the grants each year while the House bill would allow the state contribution to remain at 25%.

Chris Koyanagi of the NMHA played a lead role in efforts to establish the

Rep. George Miller, former Chair of Select Committee on Children, Youth and Families

children's mental health legislation. Koyanagi indicated that she is very optimistic that the bills will be voted on favorably when Congress reconvenes in September, 1991.

For more information on any of the bills, contact the Department of Public Policy, National Mental Health Association, 1021 Prince Street, Alexandria, VA, 22314-2971, 703/684-7722.

NEWSBRIEFS
Congressional Hearing 3
SSI Eligibility 4
ADAMHA Reorganization 7
OTA Report 14
RTI Report on CASSP 16
Robert Wood Johnson Grants 17

DEPARTMENT UPDATES
Education 8
Program Update 10
Conference Summary 15
Resources 20

BEST COPY AVAILABLE

RESEARCH AND TRAINING CENTER
FOR CHILDREN'S MENTAL HEALTH

UNIVERSITY OF SOUTH FLORIDA
FLORIDA MENTAL HEALTH INSTITUTE
13301 Bruce B. Downs Blvd.
Tampa, Florida 33612-3899
(813) 974-4500

ADVISORY BOARD MEMBERS
CHRISTINA K. YOUNG, CHAIRPERSON
Stowe, Ohio
LENORE BEHAR, PH.D.
Dept. of Human Resources
Raleigh, North Carolina
COLLEEN L. BEVIS
Tampa, Florida
ROBERT E. BRABHAM, PH.D.
National Rehabilitative Association
Alexandria, Virginia
BARBARA J. BURNS, PH.D.
Duke University Medical Center
Durham, North Carolina
WILLIAM BUZOGANY, M.D.
Mendota Mental Health Institute
Madison, Wisconsin
EUGENIA CLARK
Tampa, Florida
JOHN CLARK
Dept. of Education
Lincoln, Nebraska
ELIZABETH S. COLE
New Hope, Pennsylvania
KARL W. DENNIS
Kaleidoscope
Chicago, Illinois
STEVEN R. FORNESS, ED.D.
University of California
Los Angeles, California
GLORIA M. GRAVES
Topeka, Kansas
MARIO HERNANDEZ, PH.D.
Ventura County Mental Health
Ventura, California
GWEN IDING
Homosassa Springs, Florida
DIXIE JORDAN
PACER Center
Minneapolis, Minnesota
NAOMI KARP
Arlington, Virginia
JANE KNITZER, ED.D.
Citizens' Committee for Children of New York, Inc.
CHRIS KOYANAGI
National Mental Health Association
Alexandria, Virginia
BRENDA LYLES, PH.D.
MHMRA
New Orleans, Louisiana
IRVING PHILLIPS, M.D.
San Francisco, California
JO M. PINE, M.S.W.
Mental Health Association of LA
Baton Rouge, Louisiana
HERBERT C. QUAY, PH.D.
University of Miami
Coral Gables, Florida
BARBARA STARFIELD, M.D., M.PH.
The Johns Hopkins University
Baltimore, Maryland
JUDITH A. STURTEVANT
Morrisville, Vermont
CHRIS A. ZEIGLER-DENDY, M.S.
Lawrenceville, Georgia

U.S.F. ADVISORS
SUE BISHOP, PH.D., R.N.
RICHARD DEMBO, PH.D.
WILLIAM G. EMENER, PH.D.
BETTY C. EPANCHIN, ED.D.
LUANNE P. HOWELL, M.A.
HOWARD M. KNOFF, PH.D.
ARCHIE A. SILVER, M.D.
JUEL SMITH, PH.D.

UPDATE STAFF
ROBERT M. FRIEDMAN, PH.D.
Executive Director
ALBERT DUCHNOWSKI, PH.D.
Deputy Director
KRISTA KUTASH, M.B.A.
Deputy Director
ALISSA ALGARIN, B.S.
UPDATE Editor
FRED STARGARDT
Assistant Editor

DIRECTOR'S UPDATE

By Bob Friedman

We clearly are at a very troubling time. At a point when the needs of children and families are perhaps greater than they have ever been, not only is there an enormous federal deficit but states and cities around the country are experiencing major budget problems.

As individuals committed to enhancing the well-being of children and families and also committed to increasing the effectiveness and efficiency of our system of supports and services, how are we to respond to this situation? At the same time as we seek new revenues so that the needed supports and services can be provided, another response that we should make is to look to redirect existing resources to more humane and effective use.

As I travel around the country and colleagues tell me of the needs of children and families in their communities, more and more often I hear of families where needs for multiple services and supports exist. One modest example of this is a family that was described to me in which there are three children under the age of seven. One child already has an identified emotional disorder, a second has a physical health problem, and a third has a learning and emotional difficulty. The parents, operating on a low income and without much in the way of extra-familial supports, are struggling to make the best of their situation..

This is one of many families that I think of as being "million dollar families." By the time all of the children in this family have reached the age of 18, in all likelihood we will have spent over a million dollars of public funds on behalf of the children, despite the best efforts of the parents. And the expense may not end there — it may simply switch to a different system. In fact, if the problems aren't adequately attended to they may carry on to the next generation of family members, and beyond.

I would suggest to you that we have the knowledge and skill to identify "million dollar families" at an early stage, and we have much of the knowledge we need to provide substantial help to them. Yet we consistently fail to apply this knowledge. Why? If we were operating a business, and we identified a problem today that would eventually cost a million dollars if not fixed, you can count on the fact that we would fix that problem immediately or we would not survive in business for long.

Why then don't we apply the knowledge that we have to do this in the human services area? The answer to this question is complex but an important part of it is the way our system is set up — since the cost of serving these families is going to be spread out over a number of years, and divided in an unpredictable way between various systems (e.g, regular education, special education, mental health, child welfare, public health, substance abuse, juvenile justice), there is no fiscal incentive for any single agency to provide the needed services. Given the tight budgets that agencies have, and the lack of clear responsibility for families like this, the incentive is to delay providing service, or providing only limited service, in the hope that the problem will be inherited by some agency or system other than one's own.

As a consequence of these two factors — the lack of organizations having the clear responsibility for family-focused, comprehensive, prevention and early intervention services; and the manner in which the fiscal incentives operate — we find ourself with the humanitarian and financial tragedy of many, many million dollar families. And government at all levels gets in deeper and deeper trouble. And more and more of our children and families suffer from the lack of help provided at the right time in the right way.

Given the increasing prevalence of a wide range of problems and the shortage of needed resources, we can no longer afford as a country to pay the financial and human price for these types of system deficiencies. It is essential that they be addressed, and given the tight fiscal picture now is probably an especially good time to address this. Within this issue of Update there are articles describing important and innovative efforts to tackle this problem in the states of Iowa and Illinois. It is essential that we learn from these efforts and expand upon them so that we can avoid so much avoidable suffering and use our resources more wisely.

Continued on page 19.

64

BEST COPY AVAILABLE

Congressional Committee Discusses Systems of Care

A panel of experts presented issues concerning community-based mental health services for children before the U.S. House of Representatives Select Committee on Children, Youth and Families on April 29, 1991.

Committee Chairwoman Pat Schroeder said direct service costs for children with emotional disturbances and their families have risen to more than $3 billion a year. "Beyond the financial costs to our society is the staggering emotional cost of children's mental disorders on every member of an afflicted child's family," she said.

Rep. Frank R. Wolf, of Virginia, said that "since it is clear that institutional care is a costly and overused option and children deserve a more familial setting for treatment, our programmatic approaches must allow for innovative solutions that adapt to the changing needs of the community, yet, put children first."

Doug Wilder, Governor of Virginia, reported that the children involved in the welfare, juvenile justice, school and mental health systems are often the same children. In Virginia, 14,000 names of children across four agencies were in fact only 4,993 children. In 1989, Virginia taxpayers spent more than $100 million on group or institutional care for those children, $72.8 million of it on restrictive care.

Wilder said government must be fiscally responsible in searching for effective care. While federal reimbursements to states for foster care services have grown from $309 million in 1981 to $1.8 billion in 1991, federal child welfare funds to prevent these placements rose only 10 percent from 1980 to 1989 and currently only total $273 million, he said.

Virginia has established an interagency Council on Community Services for Youth and Families which is funded in part by redirected funds that had been used for residential care. Virginia has awarded $3.4 million to five Virginia communities to develop a system of community services.

Lenore B. Behar, Ph.D., Special Assistant for Child and Family Services, North Carolina Department of Human Resources, discussed the Child and Adolescent Mental Health Demonstration Project at Ft. Bragg, N.C. The project is developing a full continuum of child mental health services providing the most appropriate and cost effective services. The services are funded by CHAMPUS, the military's medical insurance program for dependents of soldiers.

From June, 1990 to February, 1991, the inpatient utilization rates for children have dropped from 7.0% to 1.6% of those children served.

At the same time, there has been an increase in the number of services received by children. The average cost per day for services in the Ft. Bragg project is $91.53 compared to $286.13 for CHAMPUS, Behar said.

Rep. Pat Schroeder, Chair of the Select Committee on Children, Youth, And Families

Sandra Cornelius, Ph.D., former administrator, Delaware County Government Dept. of Human Resources, said Delaware County found that by establishing community-based services, case management, and support services and using available funding, the county could support families caring for children with emotional problems and the vast majority of the children could remain at home. Cornelius said private insurance companies should be encouraged to reimburse nontraditional family-based services as a way of keeping families together and keeping costs down.

Clifford Attkisson, Ph.D., Professor of Medical Psychology, Univ. of California - San Francisco, spoke about three child services research projects that focus on implementing a model system of care. The system of care, initially demonstrated in Ventura County, is now being implemented in San Mateo, Santa Cruz, Riverside, and San Francisco. The model system of care emphasizes preventing out-of-home placement — maintaining educational achievement, reducing recidivism in the juvenile justice system, and reducing costs.

The three projects include a study of a Robert Wood Johnson Foundation project supporting the implementation of the model system of care in San Francisco, a study of the implementation of the model system of care in the other three counties (the AB377 Evaluation Project), and a National Institute of Mental Health study of clinical epidemiology in the three counties.

California has been spending more money on group homes each year ($347 million) than on any other type of out-of-home placement. In 1989, California spent 64% of the state's AFDC funds on 11,100 youth who were in group homes, according to Attkisson.

Results from an evaluation project show that establishing a model system of care can help reduce the amount of money spent on group homes. The counties in the study have a lower per capita cost for serving youth than the rest of the state, $2.78 versus $3.66. The state could have saved $171,132,063 in group home costs from February, 1989 to January, 1991 if the entire state was using the model system of care.

Attkisson gave several recommendations for the federal government to improve research on systems of care: provide training support with at least six new major training programs; develop at least six child mental health service research centers; fund research demonstration projects at the federal, state, and community levels; support development of measures and research methodology; stimulate innovation in the organization and financing of systems of care; and disseminate information about innovations and system of care knowledge.

Dixie Jordan, Parent Advocacy Coalition for Educational Rights (PACER Center), gave the legislators this advice, "services must reflect the context of the lives of youth and acknowledge that the least restrictive environment for this age group is their family homes, their schools, their communities."

Barbara Huff, President of the Federation of Families for Children's Mental Health, and George A. Rekers, Ph.D., Professor of Neuropsychiatry and Behavioral Science, University of South Carolina School of Medicine, also gave presentations.

For more information on the committee, contact the U.S. House of Representatives, Select Committee on Children, Youth, and Families, 385 House Office Building Annex 2, Washington, DC, 20515-6401.

New Regulations Increase Opportunity for Supplemental Income

The Social Security Administration (SSA) has published new regulations that will increase the number of children eligible for supplemental income and Medicaid benefits.

The new regulations require a functional assessment step to be added to the decision-making when determining if a child has a physical or mental impairment.

"These new rules are extremely significant," said Joe Manes, of the Mental Health Law Project, one of four organizations that helped the SSA draft its new policy. "It will liberalize the program and could result in thousand's and thousand's of families qualifying for the program."

Currently, about 312,000 children with disabilities receive the $407 a month benefit from the SSA. With the new regulations in place, the SSA expects to approve up to 114,000 new families over the next five years and expects to pay them up to $3.1 billion in SSI and Medicaid benefits.

Manes said the new regulations will increase the number of families approved for the benefit from last year's rate of about 50 percent to about 65 percent of the families that apply.

The new regulations, published in the February 11, 1991 Federal Register, are the result of a supreme court ruling in Sullivan v. Zebley made in February 1990. The court held that the SSA's method of evaluating children was stricter than that for adults and did not carry out the "comparable severity" standard in the law.

The SSA had been evaluating children by comparing the child's condition to those described in a "Listing of Impairments." If the child's condition did not match one in the list, the family was denied assistance. The court held that the "listings-only" approach did not provide an assessment of the child's overall functional impairment.

Under the new rules, if a child's condition does not match one in the listings, an individualized functional assessment will be completed to determine if the child has physical or mental impairments that limit him/her from functioning independently, appropriately and effectively in an age-appropriate manner. The effects of medication, structured or highly supportive settings, and multidisciplinary therapy will be considered when making the decision. Manes said applications for the program are already beginning to increase as more families learn about the new regulations. Another consideration is the families who have been denied benefits under the old regulations. "The old rules were in effect for 11 years. Any child denied benefits will have to be reconsidered," Manes said. There are about 450,000 children that the SSA knows of that could potentially be affected by the new rules, Manes said.

Manes said the SSA will try to contact those families through letters, public service announcements, and newspaper articles. If a case is reopened, and it is determined that a child would have qualified under the new regulations, the family will be reimbursed at the amount of benefits they would have received at the time. In some cases that could result in as much as $50,000 paid to a single family, Manes said.

The SSA is also currently training staff on how to apply the new regulations and cannot currently deny children unless the new regulations are applied.

For more information on the regulations, see the February 11, 1991 Federal Register or contact the Mental Health Law Project, 2021 L Street NW, Suite 800, Washington, DC, 20036-4904, 202/223-0409.

Planning Act Increases Focus on Children

In November, 1990, amendments were added to the Mental Health Planning Act that focus specifically on children. The amendments call for the development of a plan that is for children and adolescents as well as a plan for adults.

The Child and Adolescent Service System Program (CASSP) Technical Assistance Center will be calling states monthly to assist them with the new child requirements in the Mental Health Planning Act, P.L. 99-660, according to Maury Lieberman of the National Institute of Mental Health (NIMH).

The CASSP TA Center will also possibly offer critiques of state plans, Lieberman said. All of the CASSP assistance will be coordinated with other assistance provided by NIMH on the plans so there will be no replication.

The amendment emphasizes that care should be delivered in the most therapeutically appropriate and least restrictive setting. Grants provided by the amendment will be authorized for the development of comprehensive mental health systems for children and adolescents with serious emotional and mental disturbances and for adults with serious long-term mental illnesses.

The amendment requires that state mental health plans include descriptions of the health and mental health services, rehabilitation services, housing services, educational services, and other support services to be provided to individuals and children with serious emotional and mental disorders that will allow them to function outside of residential institutions to the maximum extent of their capabilities. The educational services would include services provided by local school systems under the Education of the Handicapped Act. Funding for the services is to come from federal, state and local public and private funds.

Lieberman said special workshops will be provided that will focus on interagency data collection and how to present the data that has been collected in the plan.

Clark Ross, a federal liaison for the National Association of State Mental Health Program Directors (NASMHPD) has said that the most substantial features of the amendments are the child focus, the inclusion of private sources as a resource for mental health care and the requirement of documentation of inpatient care.

NIMH is currently drafting guidelines for states that will address the legal implications of the amendments for states, Lieberman said.

Other grants that will also be offered through the amendments include prevention of youth suicide, treatment of depressive disorders, prevention of sex offenses and treatment of victims of sex offenses, and provision of mental health services to victims of family violence.

For more information on the amendments contact the National Institute of Mental Health, Parklawn Building C, 5600 Fishers Lane, Rockville, MD, 20857, 301/443-3673.

First National Conference on Conduct Disorders Held

Pathways involved in the development of conduct disorders and prevention and treatment through intensive, community-based, multi-system services were discussed at the recent conference, "Conduct Disorders: How Should our Service Systems Respond?".

The Research and Training Center for Children's Mental Health at the Florida Mental Health Institute sponsored this first national conference on conduct disorders. Approximately 100 researchers, administrators, advocates and parents attended the conference held May 6-8, 1991 in Arlington, Virginia.

Scott Henggeler, Professor of Psychology at the U.S. International University, said, "youth with conduct disordered diagnoses consume much of the resources for child mental health services, and those who persist into adulthood consume many of the services for the seriously mentally ill."

The stability of anti-social behavior over time has led to a small percentage of families accounting for a large percentage of crime in a community, Henggeler said. "Male adolescents and young adults have the highest arrest rate for violent crime," he said.

The incidence of violent crime has risen 10 percent in the last year, said James Breiling of the Violence and Traumatic Stress Research Branch of the National Institute of Mental Health.

"Just witnessing violence puts kids at risk for becoming a victim of violence or a perpetrator of violent acts," said Hope Hill, Assistant Professor in the Department of Psychology at Howard University. Hill is studying the effects of community violence on children who live in areas of high street crime.

Rolf Loeber, Associate Professor of Psychiatry and Epidemiology at Western Psychiatric Institute, describes the development of conduct disorder problems in terms of pathways. The earliest manifestations of the problem can be seen in preschool when the child shows symptoms such as attachment problems, hyperactivity, aggression, and poor peer relations. By elementary school, the child is showing academic problems, delinquency, and substance abuse.

Loeber suggested some of the risk factors which may be attributed to conduct problems include neurotoxins/neurological insult, parental substance abuse, genetic factors, pregnancy/delivery complications, socio-economic status, harsh disciplinary practices, neglect, and violence on television.

Neighborhood and the family environment also contribute to the development of conduct disorders, Henggeler said. "If you want to maximize the treatment effect you need a model that cuts across the child's social environment," he said.

Naomi Karp, Vice-President of the Federation of Families for Children's Mental Health

Henggeler gave several general principles for designing multi-systemic interventions:

* understanding the "fit" between the identified problems and the broader systemic context;
* that interventions target sequences of behavior within and/or between multiple systems;
* that the efficacy of interventions should be evaluated continuously from multiple perspectives; and
* that interventions be designed to promote treatment generalization and long-term maintenance of therapeutic change.

Steve Forness, Professor and Inpatient School Principal at the Neuropsychiatric Hospital Center for the Health Sciences at the University of California in Los Angeles, said it is currently very difficult for children with conduct disorders to be served by the schools. Children are excluded from services if their problem is considered to be social maladjustment and in many states "conduct disorder is used as a synonym of social maladjustment," he said.

According to the 12th annual report of the Office of Special Education Service, only .7 percent of children are being served as emotionally disturbed despite all reports that prevalence rates are much higher. "We should be serving about 2 percent of all school aged children in this category," Forness said.

Naomi Karp, a mental health consultant and Vice President of the Federation of Families for Children's Mental Health, said, "We have failed in schools. Special education, as it exists, is not working."

Karp said there is a need for intensive interdisciplinary training in the use of special education techniques, non-aversive techniques, and early prevention and identification of conduct disorder.

There is also a need for more interagency collaboration, said Mark Soler, Executive Director of the Youth Law Center in San Francisco. Statutory barriers to coordination and categorical funding should be eliminated, and reducing the confidentiality requirements to allow agencies to share more information would be helpful, Soler said.

Soler also believes that there should be enhanced training of staff. He said currently, social workers are trained in community support but still believe that if those options don't work, they should terminate parental rights.

Bill Graves, Director of the National Institute on Disability and Rehabilitation Research (NIDRR) announced that "one of the ways to improve the quality of life for kids with conduct disorder and all people is through knowledge." He added, "There should be intensive interaction between the recipients of research dollars and those for whom the research is intended to benefit. We want to do research with people rather than on people."

For more information about the conference, contact Alissa Algarin, Research and Training Center for Children's Mental Health, FMHI, USF, 13301 Bruce B. Downs Blvd., Tampa, FL, 33612-3899.

Children's Mental Health Needs Included in National Health Objectives

The national health objectives for the next 10 years, published in the report *Healthy People 2000*, include goals to reduce the prevalence of mental disorders among children and adolescents and increase prevention services to children.

The Public Health Service, the Institute of Medicine, and the Healthy People 2000 consortium of 300 national organizations and all state health departments released the report in September, 1990.

A similar report published 10 years ago, *Promoting Health/Preventing Disease: Objectives for the Nation*, did not include mental health issues. The National Mental Health Association (NMHA) and members of the National Prevention Coalition (NPC) have been working to ensure that a mental health objective was part of the current report.

The current report lists "Mental Health and Mental Disorders" as one of the nation's 22 priority health areas. The mental health section lists 14 national goals which include health status objectives, risk reduction objectives, and services and protection objectives.

Some of the objectives, included in the mental health section under health status objectives, focus on children and youth and include: reducing suicides among youth aged 15 - 19 to no more than 8.2 per 100,000 (1987 baseline 10.3 per 100,000); reducing by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 - 19 (no baseline available); and to reduce to less than 10 percent the prevalence of mental disorders among children and adolescents (1989 baseline 12 percent).

Under the services and protection objectives in the mental health section, is an objective to increase to 75 percent the proportion of primary care providers for children who include assessment of cognitive, emotional, and parent-child functioning, with appropriate counseling, referral, and follow-up in their clinical practices (no baseline data available).

Some of the other mental health objectives include increasing the utilization of community support programs, increasing the use of broad social support mechanisms for those with trouble coping, more attention by employers to services related to managing employee stress, and better access to mutual-help clearinghouses.

The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) will be responsible for seeing that the mental health objectives are carried out.

Advocates were pleased that the mental health objectives have been included in the report, but they strive for more emphasis on mental health and clarification in the future.

"Although the 'Mental Health and Mental Disorders' priority area should have encompassed the mental health field and referenced allied objectives in other priority areas, the content is fragmented and without internal coherency," wrote Beverly Long, NPC chair, in the September/October 1990 issue of *NPC Update*. Long said there is confusion between what is promotion of health and what is treatment to reduce severity. However, Long believes that the section offers a number of opportunities for support and advocacy.

NMHA points out that the report recognizes the demand for preventive interventions to deter disorder or disability and prevent the staggering costs that the presence of disorders or disabilities can create.

"Achievement of the Healthy People 2000 goals over the next 10 years will not only result in significantly improved health, but also economic gains for this country as health care costs are diminished," wrote Sandra McElhaney, prevention coordinator for NMHA.

For a copy of the report Healthy People 2000 (stock number 017-001-00474-0) write the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402-9325 or call 202/783-3238. The report costs $31.00.

Child and Adolescent Service System Program Update

By Judith Katz-Leavy, Chief Technical Assistance Program and Diane Sondheimer, Chief, Research Demonstration Program.

Dr. Ira S. Lourie, who had served as the first and only Chief of the Child and Family Support Branch of the National Institute of Mental Health (NIMH) and as the leader of the Child and Adolescent Service System Program (CASSP) since its inception in 1983, retired from federal service on March 29, 1991.

Dr. Lourie will continue to work in the field of public child mental health as a consultant on both the state and federal levels, however, his formal leadership of CASSP at NIMH will be deeply missed.

Currently in its seventh year, CASSP has been active in all 50 states, the Virgin Islands and the District of Columbia.

The Branch will also administer a new Child and Adolescent Mental Health Research Demonstration program. Based on recommendations in the National Plan for Research on Child and Adolescent Mental Disorders and as part of the NIMH Public-Academic Liaison initiative, a Program Announcement (PA-91-40) has been released to stimulate investigator-initiated research demonstration projects (R18s) of state and local-level service systems for children and adolescents with or at risk for serious emotional or mental disorders.

In FY90, in response to a Request for Applications (RFA) for CASSP-related R18s, the Child and Family Support Branch funded 8 projects and is in the process of funding 3 additional projects. Individuals interested in obtaining further information are encouraged to contact program staff at 301/443-1333.

For more information on CASSP, write the National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD, 20856, 301/443-3673.

Call for Papers for 5th Annual Research Conference

Suggestions and abstracts are now being accepted for the Research and Training Center for Children's Mental Health's 5th annual research conference, "A System of Care for Children's Mental Health: Organizing the Research Base." The conference will be held March 2 to 4, 1992 at the Hyatt Regency Tampa in Tampa, Florida.

If you are interested in presenting either a paper or poster at the conference, send a 300 word abstract to the Research and Training Center by October 1, 1991 to Dr. Al Duchnowski, Director of Training, Consultation and Dissemination, Research and Training Center for Children's Mental Health, Florida Mental Health Institute, USF, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899.

For more information on submissions call Dr. Al Duchnowski at 813/974-4500. Watch for more information in future mailings.

Reorganization of ADAMHA to Bring Changes to NIMH

The three research institutes of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), including the National Institute of Mental Health (NIMH), are to be transferred to the National Institutes of Health (NIH), and a new federal agency to administer mental health and substance abuse services is to be created, according to a proposal announced on June 17, 1991.

The proposed change was announced by Dr. Louis Sullivan, Secretary of the Department of Health and Human Services. This announcement was accompanied by the introduction of S. 1306, entitled the ADAMHA Reorganization Act, by Senator Edward Kennedy of Massachusetts and Senator Orrin Hatch of Utah, the ranking senators on the Committee of Labor and Human Resources.

The proposal would transfer NIMH, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to NIH. At the same time, ADAMHA will be converted to the Alcohol, Drug Abuse, and Mental Health Services Administration (ADAMHSA), according to S. 1306.

Within ADAMHSA will be the Office for Substance Abuse Prevention and the Office for Treatment Improvement, both of which currently exist within ADAMHA, and a new Office for Mental Health Services. S. 1306 calls for separate Associate Administrators for Mental Health and Substance Abuse.

According to Secretary Sullivan, "The Institutes in NIH and those transferred from ADAMHA will benefit from the greater exchange of information and the sharing of expertise in neuroscience and behavioral research."

Missions Separated

In introducing the legislation in the Senate, Senator Kennedy indicates that, "We have examined whether it is useful to ask a single agency to research the causes and the cures of a disease at the same time that it provides services to those suffering from the disease ... Our conclusion is that the present configuration of ADAMHA is not appropriate... It might seem logical to keep research and services under the same roof in order to facilitate 'technology transfer,' the process by which research findings are applied in the field. In practice, however, the research and service enterprises are so different that they cannot be effectively administered in one agency. Researchers and service providers share a common goal, but they speak a different language and thrive in different professional cultures."

CASSP Fate Unknown

According to Dr. Thomas Plaut, Acting Chief of the Child and Family Support Branch of NIMH, the organization of the children's mental health programs is still under discussion. "There is some talk that different components of CASSP should be split, but there is no consensus," Plaut said. CASSP includes a state grant program for system capacity building, technical assistance components including research and training centers and the CASSP Technical Assistance Center, and a research demonstration program.

In his remarks, Senator Kennedy indicated that, "the statutory authority to conduct services research, most of which would be characterized as behavioral research, is to be transferred with the research institutes. There are, however, existing ADAMHA programs which have been labeled as services research but which have come to be relied on by the field as services. These grant programs will remain in ADAMHSA." No specific mention of CASSP is made in this comment, however.

Senator Kennedy also notes that, "While the research institutes are leaving ADAMHA, we recognize that it would be unwise to create a services agency that spent money without the authority to help determine which types of services work, and which work best. Our bill addresses this concern in two ways. First, ADAMHSA will have an independent obligation to evaluate the programs it funds. Second, there will still be substantial opportunities for collaboration between the research institutes and the Services Administration."

In his comments, Secretary Sullivan announced his intention to appoint Dr. Frederick K. Goodwin, current administrator of ADAMHA, as Director of NIMH. Dr. Goodwin is a psychiatrist and biomedical researcher, and one of the main architects of this reorganization, along with James O. Mason, M.D., Assistant Secretary for Health of HRS, and Bernadine Healy, M.D., Director of NIH.

Secretary Sullivan also indicated that ADAMHA's deputy administrator, Robert L. Trachtenberg, would be named acting administrator of ADAMHSA while a national search is made for a permanent administrator. Frank Sullivan, Ph.D., whose former positions include Acting Director and Deputy Director of NIMH, would serve as Acting Director of the new Office of Mental Health Services within ADAMHSA.

Advocacy Reaction

The proposal for reorganization was strongly supported by the National Alliance for the Mentally Ill. Executive Director Laurie M. Flynn indicated that, "Moving NIMH to NIH sends an important signal that mental illness is a disease, like heart and lung and kidney disease. It is at NIH that mainline research on organic diseases is centered."

The proposal, which is expected to be approved by Congress, and implemented in the fall of 1991, also has the support of the National Association of State Mental Health Program Directors (NASMHPD), and the National Mental Health Association (NMHA). In testifying on S. 1306 on June 25, 1991, on behalf of NASMHPD, Commissioner Dennis Jones of Texas indicated that the basic reorganization proposal made sense. He did call for "a strong and viable services research and demonstration responsibility" within ADAMHSA, indicating that "this would afford public mental health systems with the technical assistance and capacity to review financing, organizational structures, and methodologies to improve mental health services for persons with serious mental illness."

Testifying on behalf of NMHA, Elisabeth Rukeyser of Knoxville, Tennessee applauded the establishment of OMHS within ADAMHSA, urged retention of CASSP and the Community Support Program in OMHS, and called for "a strong, viable, and valued services research component in ADAMHSA."

EDUCATION

Special Education Report Released

Outcomes of Special Education Programs

	All	LD	MR	SED
% Receiving Failing Grades	31	35	22	45
Grade Point Average (4 Point Scale)	2.0	1.9	2.0	1.7
% Graduating or Certificate	53	56	56	36
% In a Regular School Bldg.	94	99	89	81
% In Residential Placement	0.80	0.09	1.02	3.46
% On Homebound or Hospital Instruction	0.72	0.12	0.34	2.21
% Increase Need of Teachers	9	8	8	15

KEY - All = all disabilities **MR = mental retardation**
LD = learning disabilities **SED = serious emotional disturbance**

An analysis of the "Twelfth Annual Report to Congress on the Implementation of the Education of the Handicapped Act" reveals a situation in which children who have serious emotional disturbances continue to fare poorly in comparison to other groups of youngsters who have disabilities.

In each category, results for the group with emotional disturbance were worse than for all other types of disabilities.

During the '88-'89 school year, the number of children served through all of the categories provided by the act increased 1.76%. (All data are for children who are 6 to21). The increase in learning disabilities was 3.03%, 1.56% for speech impaired, and 0.69% for emotional disturbance. The total percent of all children served as part of special education programs were: all conditions—7.41%; learning disabilities—3.53%; speech impaired—1.71%; mentally retarded—1.03%; and 0.67% for emotional disturbance.

In the table above, several findings are summarized comparing all exceptionalities (ALL), learning disabilities (LD), mental retardation (MR), and emotional disturbance (SED). These results indicate that children who have serious emotional disturbances: have the poorest academic success, including graduation rate; are taught in the least normalized settings; and need more teachers at a rate almost double the other exceptionalities. All of these findings are consistent with those reported in the last several years.

When the report compared different rates of children served by the states, more variability in the rate of children who have emotional disturbances was found than the other exceptionalities. Mississippi identified 0.03% of the state's population of children as having serious emotional disturbances. Utah served 1.74%, the highest rate of any state, and 58 times higher than Mississippi. In contrast, the difference between the highest and lowest rates for learning disabilities is a factor of 3.5 and 2.3 for all handicapping conditions.

In twenty states, the rate of children served as emotionally disturbed actually decreased, the highest number of reductions for all conditions. In the District of Columbia, for example, there was a decrease of 27.6%, while the percent served as learning disabled increased 52.6%. The Department of Education reports it is beginning a study to improve the comparability of data between states.

Copies of the report may be obtained from the Office of Special Education and Rehabilitative Services, Switzer Building, 330 C Street, S.W., Washington, DC, 20202.

Unique Meeting Held on Collaboration Between Systems

Denver, Colorado was the site of a unique meeting, October 3-5, 1990, at which 10 states came to grips with developing action plans for a collaborative system of care for children who have serious emotional problems and their families. Glenn Latham, Director of the Mountain Plains Regional Resource Center (RRC), and Richard Zeller, Director of the Western RRC led the conference.

The program was designed to allow state leaders in special education and mental health to meet with each other and representatives from other child caring agencies in their states and to assess and improve their state's service system for children who have serious emotional disturbances and their families. A parent representative was also a member of each state team.

The goal of the meeting was for each state team to leave the meeting with a written action plan, specific to their state, that would result in improved services for children who have serious emotional disturbances and their families. Implementation of the plans would be realistic since the participants were at the decision-maker level.

More than 60 participants from 10 states attended, with several states bringing representatives from child welfare and juvenile justice agencies.

The conference was keynoted by Dr. Judy Schrag, Office of Special Education Programs (by speaker phone) and Dr. Ira Lourie, formerly of the National Institute of Mental Health. In the spirit of collaboration, remarks were made by representatives of the State Mental Health Representatives for Children and Youth, the National Association of State Directors of Special Education, and the Federation of Families for Children's Mental Health. State-of-the-art program presentations described efforts in Alaska, California, Kentucky, and Vermont.

For more information, contact Dr. Glen Latham, Mountain Plains RRC, 1780 North Research Parkway, Suite 112, Logan, UT, 84321, 801/752-0238.

Mental Health - Special Education Coalition Reaching Goals

The National Mental Health-Special Education Coalition has seen one of its goals achieved with the targeting of $1.9 million in federal discretionary funds for the area of emotional disturbance. This money is part of the allocation used to fund PL 94-142, and the Coalition has worked hard to ensure that at least some of the discretionary money in this allocation would be used specifically for programs in the category of serious emotional disturbance.

Coalition members have attended meetings with Dr. Judy Schrag, Director of the Office of Special Education Programs, to give input on the specifics of how this discretionary money should be spent. These details will be announced soon.

Another of the Coalition's projects is closer to realization with the introduction of the "Children's and Communities' Mental Health Services Improvement Act" in the U.S. Congress under the sponsorship of Rep. George Miller of California. The proposed bill would establish a grant program for states to receive federal funds to create mental health services that are necessary to complete the system of care for children who have severe mental or emotional disturbance.

A third project of the Coalition, led by Dr. Steve Forness, U.C.L.A., and Dr. Jane Knitzer, Citizens' Committee for Children of New York, has been seeking a new definition of serious emotional disturbance which would be recommended for use in the Individuals with Disabilities Education Act (PL 94-142). Several associations that are members of the Coalition have examined the proposed definition and, with minor revisions, are close to supporting it for adoption by their membership. The proposed definition will be presented to the Department of Education and appropriate committees in Congress.

The Coalition is co-chaired by Chris Koyanagi of the National Mental Health Association and Joe Ballard of the Council for Exceptional Children. For more information, contact Chris Koyanagi, Director, Federal Relations, NMHA, 1021 Prince Street, Alexandria, VA, 22314-7722, 703/684-7722.

Knitzer's Book Examines the Educational System

Jane Knitzer, author of "Unclaimed Children" (1982) and director of The Citizen's Committee for Children of New York, has published a book that examines the inadequacies of the education system in helping children with emotional problems.

"At the School House Door," co-authored by Zina Steinberg and Brahm Fleich, is a report "intended to serve as a map of promising programs and policies, as well as to synthesize what is known about the characteristics of the students and the quality of their school life."

According to Marian Wright Edelman, of the Children's Defense Fund, "The report provides an agenda for reform that must involve all appropriate public child serving agencies, as well as a variety of community agencies."

Knitzer said a large number of school districts across the country have ordered the book. "This suggests that the climate is really right for taking a hard look at these issues," she said.

The information presented in the book was gathered through site visits to 26 programs, phone interviews with staff from 130 programs, a review of the relevant literature, and questionnaires completed by state directors of special education, child mental health officials, and parents.

The book begins with data from the 1987-88 report to Congress on the implementation of the Education of the Handicapped Act (now titled the Individuals with Disabilities Education Act). The book points out that less than half of all school districts reported having mental health counseling services and the number of children with emotional disturbances using the services could not be determined. The report listed a dropout rate of more than 50 percent, poor achievement scores, and no effective transition services for children with emotional problems.

The book went on to analyze the day-to-day life of students in a program for children with behavior disorders and found a widespread abuse of behavior modification methods. In class after class, the authors observed teachers who were more focused on controlling the behavior of students than with academics. A sense of isolation emerged in the students, their teachers, and their parents, according to the authors.

The second part of the book presents an in-depth look at programs that reveals a wide variety of approaches.

In the third section of the book, the role of the state in supplying leadership for change is explored. The authors describe examples from 16 states in which the commitment to collaboration is strengthened through grants, legislation, and innovation. The authors advocate new legislation, collaborative ventures, and the pooling of funds to reinvest the money in community based programs.

Finally, the authors present a blueprint in which educators, clinicians, policy makers and parents are challenged to take the necessary steps to develop an agenda of change. The appendices offer sources of help, names, addresses, helpful facts, and definitions of important terms.

To order a copy of the book, send a check or money order for $17.50 to the Citizen's Committee for Children of NY, 105 East 22nd Street, New York, NY, 10010.

Mark your calendars for the 5th Annual Research Conference: March 2 to 4, 1992 at the Hyatt Regency Tampa: Tampa, Florida

PROGRAM UPDATE

Strength-Based Assessment

By Michael K. Johnson, Ph.D. and Robert M. Friedman, Ph.D.

John is a 16-year-old who was first identified as having learning problems in the first grade and was retained in his same grade. He not only displayed academic difficulties, but was reported to be restless and inattentive in class, and by the fourth grade he had been identified as being both non-compliant and aggressive. He has been in and out of special education classes, and has had several encounters with the law. While he appears very sad in group situations, in a one-to-one situation, he is described as being very likeable, and he has a strong interest in electronics. His parents have been very responsive to suggestions from professionals for help but find themselves wondering just what it is they have done wrong that has led to John's problems. The family is concerned about the problem, and has participated in family therapy but terminated it after feeling that it was not helpful. John himself has been involved in individual therapy but his attendance was erratic, he often sat quietly, and still the problems seem to grow. Finally, John and his family were scheduled for a multi-agency treatment planning meeting in their community. At this meeting they sat with about 10 individuals representing different agencies and professions, and essentially listened as the group discussed all the individual and family problems, and sought to develop a treatment plan. By the end of the meeting, both John and his parents felt more discouraged and defeated than they had when they entered the meeting.

In previous issues of UPDATE, articles have focused on topics such as case management, individualized treatment, and treatment planning. This article builds on these previous writings to specifically emphasize an important and yet often overlooked part of developing effective individualized treatment plans — the assessment of individual and family strengths. As the brief description of a simulated case, presented above, illustrates, all too often there is almost an exclusive focus on problems and deficits of an individual, and of his/her family. This frequently occurs at the intake level in individual agencies, as well as at the treatment planning level. For individuals and families who are already feeling inadequate, if not depressed, and who are not sure if they wish to continue their involvement in special services, the result of focusing on the negative can be to drive them into greater despair and further away from seeking help. This section of UPDATE seeks to focus specifically on assessment of strengths and interests because of the importance of this area in engaging individuals and families who are already feeling inadequate and distraught, and the importance of this in beginning an effective interventjon process.

Background

The idea of developing interventions based on strengths is not new in working with children with disabilities and their families. However, it is a concept that has often been neglected by mental health providers who instead have been wedded to models that focus almost exclusively on the identification of problems and deficits. Dr. Elizabeth Mount, a political scientist who has worked in the developmental disabilities field since the mid-1970s, suggests that strength or capacity-based assessment evolved originally from a model for providing economic aid to developing third world countries (Mount, 1987). As planners entered third-world countries they found that the sheer number of problems they encountered were so overwhelming that they provided a poor starting place for achieving change. Rather than get bogged down in identifying ways to remediate each problem, these planners chose to look at the situation from the perspective of "what kind of strengths and resources does this country have, and how can we enhance and build upon them for the good of all involved?" Mount developed a model called "Personal Futures Planning," based on this philosophy. She notes that while this model was originally developed for use with children who have developmental disabilities, it has recently begun to be used for treatment planning in collaboration with children with challenging emotional difficulties and their families.

"Our focus on strengths as opposed to problems significantly decreases the amount of conflict between parents, children and agencies as it unifies them in a building process."

— John Poertner

Karl Dennis, Director of the Kaleidoscope program in Chicago, indicates that the focus on strengths "is more than just a process...it's a philosophy and a whole different way of looking at kids who are troubled or troubling. The process is based on trust, and building a relationship with a child and his or her family. You have to believe that the child and his or her family and/or friends really know what is best for them."

John Poertner of the University of Kansas continues this thought. "In mental health, we have so much to learn from the developmental disabilities fields...The way we see it, problems and deficits take a back seat, or shouldn't be focused upon...Our focus on strengths as opposed to problems significantly decreases the amount of conflict between parents, children and agencies as it unifies them in a building process. Our model is focused on functional adaptation rather than on deficits." Currently, Poertner is writing a manuscript on how to conduct strength-based assessments.

Another proponent of focusing on strengths is Jane Wells, who has developed a training curriculum based on the early work of Mount in "Personal Futures Planning." She agrees with Poertner that the focus of the strength-based assessment needs to be on the future, and on developing the strengths and talents of the child and doing whatever it takes to ensure that the child can live independently and productively in the community.

In Wells' model, even the designation for the child is different. The child is known as the "focus person" to avoid deficit model references such as identified patient, client, etc.

Within assessment models that focus on strengths, there is acknowledgement that important problems exist in the lives of the individuals. However, the model asserts that strengths and capacities are the building blocks for change and should receive primary emphasis.

In discussing challenges facing the children's mental health field in the '90s, Duchnowski and Friedman (1990) acknowledge that there is an important role for traditional models of assessment. However, they go on to emphasize that to genuinely develop individualized treatment programs, the field must rely "not only on a traditional assessment but on a broader ecological assessment. The program must address not only needs and problems, but it must also build on strengths and interests."

Assessment Models

The Personal Futures Planning model is used to develop treatment plans for children referred for interagency staffings at the Child and Adolescent Service Center in Canton, Ohio. As described by Michael Johnson and Thelma Coss of that agency, whenever possible staffings are held in a setting other than the Center or a school in an attempt to "de-institutionalize" thinking. The participants include the child, parent(s), professionals from involved agencies, and any and all other people who have an interest in the focus person.

In following the Personal Futures Planning model, the parent(s) is asked to tell the story of his or her child's life. Others who have knowledge also contribute in order to produce a comprehensive, ecologically focused story of the child's life. "The life story process serves two purposes: First, it allows the parents to tell their story and be heard without being judged, which, for many of our parents, is the first time they've ever been able to do this. Second, it really engages all the members of the team. In a sense, they all become co-authors in this very compelling story," reports Coss.

Johnson adds that, "After the story is laid out, we are able to see clear patterns of variables and events that tend to precipitate crises. Most important, however, is that we are also able to very clearly see the strengths that are present that can be built upon or enhanced to prevent crises in the future."

At the Kaleidoscope program, the process is less formal. It starts by finding out who a child trusts and who knows the child best. After this is done, according to Dennis, it then becomes important to find out what a child likes, and to focus on these likes. "If problems are readily identifiable, we do everything we can not to get stuck on them, and to reframe the problems as strengths. For instance, if a child is aggressive, one approach may be to involve the child in a Gold Gloves Boxing program. If a child is really obsessive-compulsive, the child should be allowed to use that as a strength and be involved in a vocational program that rewards such traits, such as hotel maintenance," reports Dennis. He further indicates that, "I believe that what's more important than having assessment tools or a formalized process is that you must have a positive attitude toward working with these kids, and you must foster a positive atmosphere toward the child. If you can't do this and you can't figure out what a child's strengths are, then you have no business working in the field."

An important aspect of identifying strengths is to have the ability to view values, attitudes, beliefs, and behaviors within a cultural perspective. Marjorie Sullivan of the Edna S. McKinley Center on Chicago's south side, indicates that "It is essential to obtain an understanding of what is functional and adaptive behavior within a given culture, and to be sensitive to areas of differences between the therapists' culture and the clients'. We work with our therapists to get them to attend to both the verbal and the nonverbal behavior of their clients. If a therapist is culturally naive, they are unable to ask for clarification of words or actions of their clients that they do not understand. This misunderstanding frequently leads to agencies labeling behavior disturbed or pathological when, in fact, it is quite adaptive."

At the Progressive Life Center in Washington, D.C., the focus on strengths is incorporated within an assessment and treatment approach that is based on principles of Afrocentric Spirituality, according to agency director Fred Phillips. He indicates that the assessment process is comprised of both traditional and non-traditional methods, including methods such as "family sculpting and culturally specific questionnaires to look at such things as self esteem, values, and beliefs as they relate to a child's race or culture."

Use of Strengths and Interests in Developing Treatment Plans

One of the best known models of individualized care is the Alaska Youth Initiative, developed initially to bring Alaska youngsters who were placed out of their state back within Alaska. As John VanDenBerg, director of the Alaska Youth Initiative until April 1991, describes the model, the emphasis in assessment is not to simply look at the availability of existing services, or the problems that are presented. Rather the emphasis is on assessing strengths, normal developmental needs, and creative solutions, even though they may initially appear to be impractical. The task of taking what may appear to be impractical and making it practical is a challenge to be faced by the treatment team in this model.

VanDenBerg (1990) presents an example of a 16-year-old Eskimo youth, whose sole interest was in fishing, an interest that had not been capitalized upon in his out-of-state placement. This youngster was without a family with whom he could live, and got along best with young adults. Based on the assessment of strengths and interests, the treatment plan focused on identifying an appropriate young Indian, in his twenties, who was a commercial fisherman, with whom this youngster might reside and receive training to himself become a commercial fisherman.

Jacqueline Jones, Executive Director of Black Family Development, Inc., in Detroit, describes a referral that her agency received from the local child welfare agency which had identified a

need to remove three children from their mother because the children were reportedly abusing the mother. She reports that upon visiting the family, her staff found that the "two biggest children were indeed holding down the mother while the third took the family's food stamp coupons from her so the oldest child could go buy groceries. The mother, it turned out, had a fairly serious substance abuse problem which was preventing her from attending to the basic needs of her children. Rather than viewing the children's behavior as abusive, we saw it as being adaptive in that they were resourceful enough to do what was necessary to provide for themselves during some very tough times. We were able to get one of our in-home therapists to work with this family, the mother went through a rehabilitation program, and now the family is doing quite well. Had we initially gone in and removed the children as was suggested, this family may have never recovered," she reports.

Within a South Carolina agency, called the Continuum of Care, flexible money is used to purchase the services of "positive role models" for youngsters. These role models are selected on the basis of sharing interests with the youngsters with whom they will work. Similarly, case managers in Florida seek to identify individuals who share specific interests with youngsters. These individuals then serve as combination respite care workers, big brothers, and para-professional counselors.

To build on the strengths and abilities of particular youngsters served within their program, Kaleidoscope staff have assisted in the development of small businesses. This approach puts a new meaning to the concept of "capitalizing" on strengths and talents.

Preparing Staff to Implement Strength-Based Assessments

Based on his visits to sites around the country, Research and Training Center Director Bob Friedman reports that there is far more discussion about using strength-based approaches than there is actual implementation of them. He indicates that many individual programs and state offices have begun to include on their specific assessment forms a spot to list strengths and interests, both of the child and the family. "There are typically far fewer strengths listed than problems, however, and in most cases the treatment plan that is developed does not build on the strengths. The approach of requiring that reports and assessment procedures specifically identify strengths is certainly a step in the right direction. However, the pattern of most professionals of focusing almost exclusively on problems is not easy to break, and there needs to be considerable training if we are to move beyond just rhetoric and actually begin to build treatment plans based on strengths."

One approach to training involves groups going through the process of developing treatment plans for real or simulated situations under the direction of facilitators. According to David Fairbanks of the SEDNET program in Tallahassee, Florida, and Kathy Roberts of Northside Centers in Tampa, this approach can be very revealing. They describe a recent training session they conducted for case managers that involved developing a treatment plan. Overall, the group listed less than five strengths for the youngster and family while creating an extensive list of problems. One of the effects of this was to leave the group feeling overwhelmed and discouraged.

Upon prompting by Fairbanks and Roberts, the group expanded the list of strengths, and proceeded to develop treatment plans specifically building on the strengths. This created a much more hopeful and optimistic feeling amongst the participants, and helped them recognize their strong habit of focusing almost totally on problems.

Part of the process of changing this habit, in addition to training, should be careful review of assessment procedures, the results of assessments, and the final treatment plans. These reviews can help insure that the assessment and treatment planning did include a strong focus on strengths.

An additional aspect of this review process can be consumer feedback to determine the satisfaction of both the youngster and family with the entire assessment and treatment planning process. This mechanism, which can be systematized and made a routine, ongoing part of standard practice, can specifically ask about the focus of the assessment and can provide valuable information for all of the participants in the assessment and treatment planning process.

Advantages and Limitations of a Strength-Based Approach

One of the advantages of a strength-based approach, used as part of an overall individualized treatment planning process, is that it operationalizes basic values of a system of care (Stroul & Friedman, 1986). As described by individuals who utilize this approach, it also serves to promote creativity and innovation, and to secure information from a variety of sources. Another potential benefit is that it may be a more successful way of engaging youngsters and families in treatment, particularly when these youngsters and/or families are not certain they are interested in treatment or have a long history of feeling mistreated by professionals.

The intuitive and affective appeal of this methodology is quite strong. Therein, however, may lie the most significant concern about the approach. To date, while there are some encouraging research findings on individualized treatment approaches, there is little empirical research on the utilization of this strength-based assessment approach. In particular, there is very little knowledge on the manner in which a focus on strengths and the assessment approaches which permit such a focus can best be combined with traditional assessment methods, and with appropriate attention to problems and deficits.

The broad challenge to the field is how to develop and evaluate the most effective assessment and intervention approaches based on new developments in assessment and individualized treatment planning, such as those described here, and the best of the more traditional procedures.

References and Contacts

Black Family Development Inc. information available from: Jacqueline Jones, MSW, Exec. Director, Black Family Development Inc., 15231 W. McNichols, Detroit, MI, 48235.

Child and Adolescent Services Center information available from: Michael Johnson or Thelma Coss, Child and Adolescent Services Center, 1226 Market Ave. N., Canton, OH, 44714-2658.

Creative Community Options information available from: Jane Wells, Creative Community Options, 4209 Oakmeade Ln., White Bear Lake, MN, 55110.

Duchnowski, A.J. & Friedman, R.M. (1990). Children's Mental Health: Challenges for the 90s. Journal of Mental Health Administration, 17, 3-12.

Edna S. McKinley Intervention Services information available from: Marjorie Sullivan, LCSW, ACSW, Division Director, Edna S. McKinley Intervention Services, 2717 W. 63rd St., Chicago, IL, 60629.

Kaleidoscope information available from: Karl Dennis, Executive Director, Kaleidoscope - Chicago, 1279 N. Milwaukee, Suite 250, Chicago, IL 60622.

Kansas information available from: John Poertner, DSW, University of Kansas, School of Social Welfare, Twente Hall, Lawrence, KS, 66045.

Mount, E. (1987). Personal Futures Planning: Finding Directions for Change. Unpublished Doctoral Dissertation. University of Georgia. Or contact Elizabeth Mount, Ph.D., 25 W. 81st St. New York, NY, 10024.

Northside Centers Inc. information available from: Cathy Roberts, MS, Coordinator Clinical Case Management - Northside Centers Inc., 13301 Bruce B. Downs Blvd., Tampa, FL, 33612.

Progressive Life Center information available from: Fred Phillips, Psy.D., Progressive Life Center, 1123 11th St. NW, Washington, DC, 20001.

SED Network information available from: David Fairbanks, Ph.D., SED Network Project Manager, 1940 N. Monroe St., Suite 50, Tallahassee, FL, 32303.

Vandenberg, J. (1989). The Alaska Youth Initiative: An Experiment in Individualized Treatment and Education. In A. Algarin, R. Friedman, A. Duchnowski, K. Kutash, S. Silver, & M. Johnson (Eds.), 2nd Annual Conference Proceedings, Children's Mental Health Services and Policy: Building A Research Base. Tampa, FL: Florida Mental Health Institute.

Advocacy Groups Strive to Improve Services

National advocacy organizations are formulating plans to improve services for children who have serious mental illnesses and emotional disturbances and to increase support for their families.

NAMI CAN, the child and adolescent network of the National Alliance for the Mentally Ill met in Chicago this past summer and announced a comprehensive network plan entitled "Moving Mountains." Several resolutions were adopted, advocating for an end to the need to relinquish custody to obtain services, better insurance coverage for mental illnesses, and improved educational programs.

NAMI

An eleven-point goal statement was adopted, including one which challenged policy makers to place the needs of children who are mentally ill and their families at the top of the national agenda. In addition to advocacy activities, NAMI CAN has developed several support activities for children and their families. For example, pen pal clubs have been established for children who have mental illness and their siblings.

On November 9-11, 1990, The Federation of Families for Children's Mental Health held their annual conference in Arlington, Virginia. In its second year, the Federation membership has grown to 500 family members, professionals, advocates, and interested citizens.

National Mental Health Association

More than 120 participants from 33 states "Dared to Dream" and then strategized to make their dreams of an improved system of care come true. On the 9th, a full-day, intensive workshop was held for the state contacts. Topics ranged from developing parent support groups to increasing membership.

During the main conference sessions, the emphasis was on the federal role in meeting the needs of the children and their families. Federation president, Barbara Huff of Kansas, moderated a program featuring representatives from the National Institute on Disability and Rehabilitation Research, the National Institute of Mental Health, the Administration for Developmental Disabilities, Office of Special Education Programs, Social Security Administration, and the National Parent Network on Disabilities. The message from these agencies was uniform and clear—no longer would families be left on the sidelines, they would play a meaningful role in all aspects of policy development and service implementation.

The National Mental Health Association has concluded a three-year children's campaign by producing a new guidebook for parents. "Troubled and Troubling Children: A Guide for Parents Seeking Help for Their Children With Emotional Disorders" is a culmination of the educational campaign, "Remember the Children," which addressed the serious shortage of services, funding, and research targeted for children's mental health.

The guide offers parents solutions and resources for obtaining help through the schools and the mental health system.

"Parents are finally being freed from guilt and armed with information that addresses the confusion of serious emotional disorders and the frustration in getting appropriate treatment and services," said Elisabeth Rukeyser, NMHA's chair of the board.

For more information on the activities of the groups listed above contact:

*The NAMI CAN chairperson, Rebecca Viers-Padilla, 7732 Hermanson Place, NE, Albuquerque, NM, 87110, 505/296-5317.

*Federation of Families for Children's Mental Health, 1021 Prince Street, Alexandria, VA, 22314-2971, 703/684-7710.

*National Mental Health Association, 1021 Prince Street, Alexandria, VA, 22314-2971, 703/684-5968 or toll free 800/969-NMHA.

BEST COPY AVAILABLE

OTA Report Takes Holistic Approach to Health

The Office of Technology Assessment (OTA) has gone beyond basic physical and mental disorders in their recent report on adolescent health.

In the report, "Adolescent Health: Volume I — Summary and Policy Options," the OTA defines adolescent health as including social competence, perceived quality of life (from the adolescent's point of view), and consideration of social (communities, public policies, etc.) and physical (fluoridation, automobile and highway design, etc.) influences on health.

The OTA found that adolescents face formidable barriers in obtaining health care and adolescents who are both poor and members of racial or ethnic minorities are particularly at risk in terms of health problems and access to services.

The report looked at a number of health-related issues including school problems, chronic physical illness, nutrition and fitness problems, AIDS and sexually transmitted diseases, pregnancy and parenting, homelessness, and mental health.

The report stated that 18 to 22 percent of adolescents experience diagnosable mental disorders, primarily conduct disorders, and 10 percent of adolescents ages 10 to 17 have multiple serious behaviorally based problems.

Program development needs listed in the area of mental health include social competency-based mental health promotion efforts, information to adolescents about when and how to seek mental health services, systematic comparisons of inpatient versus outpatient treatment, innovative approaches to case management and financing, and innovative treatment approaches, such as home-based and therapeutic foster care.

Identification of adolescents as needing help is often based on adolescents' outward behavior rather than adolescents' subjective distress. "When asked, an average of one out of four adolescents report symptoms of emotional distress and the rate is higher among rural and Native American adolescents," according to the report.

The rate of suicide, one of the most severe manifestations of subjective distress, has increased three times among adolescents since the mid-1950s. According to a 1987 National Adolescent Student Health Survey, one out of seven 10th graders reported having attempted suicide.

While access to mental health services has increased, it is still very limited, according to the report. Medicaid and private insurers place limitations on reimbursement for mental health services that they may not place on services for physical problems.

Research is essential on the availability and effectiveness of standard providers and settings and promising innovative treatments and approaches, such as home-based care, crisis intervention services, therapeutic foster care, transitional living, partial hospitalization (day treatment), and "wraparound" services, the report states.

The OTA suggested a range of options that Congress may want to consider including improving adolescents' access to appropriate health services, restructuring and invigorating Federal efforts to improve adolescent health, and improving adolescents' social environment.

Some strategies suggested to improve access to health services include: supporting the development of health centers specifically for adolescents in schools and communities; increasing financial access to health services, and increasing legal access to health services through substantive changes in consent and confidentiality regulations.

Strategies suggested to restructure federal efforts include creating a new locus for a strong federal role and strengthening traditional U.S. executive branch activities in program development, research, and data collection.

Some of the strategies suggested to improve the social environment for adolescents include: increasing support to families of adolescents; supporting additional limitations of adolescents' access to firearms; and supporting expansion of recreational opportunities for adolescents.

For a copy of the report "Adolescent Health: Volume I — Summary and Policy Options," stock number 052-003-01234-1, send a check for $9.50 to the Superintendent of Documents, U.S. Government Printing Office, Washington, DC, 20402-9325 or call 202/783-3238.

BEST COPY AVAILABLE

Conference Summary:

4th Annual Research Conference

Research on organizing and financing community-based systems of care for children and their families is an area of increasing importance in the current economically difficult times, according to researchers at the fourth annual research conference of the Research and Training Center for Children's Mental Health of the Florida Mental Health Institute.

The conference, "A System of Care for Children's Mental Health: Expanding the Research Base," held February 18-20, 1991 in Tampa, FL drew more than 300 researchers, policy makers, administrators, clinicians, advocates, and parents from 38 states, Washington, D.C. and Canada. Information on current research in the area of organizing children's mental health services was presented by more than 60 national leaders in the field.

Dr. Robert Friedman, Center Director, said that now, more than ever before, "public policy makers are asking the hard questions about services — what services are we providing and how does that compare with what we should be providing, how can we best organize the services so that they form a coherent and cohesive system, how should they be funded, what types of outcomes are we achieving, and how can we improve these outcomes?" Friedman said these questions demonstrate the need for strong programs of research on service delivery and systems of care.

Dr. Jack Burke, Jr., Director of the newly formed Division of Applied and Services Research at the National Institute of Mental Health (NIMH), said one benefit of the new division should be a closer collaboration between service system researchers and policy makers. He said funding opportunities for child mental health services research will be enhanced.

Dr. William Graves, Director of the National Institute on Disability and Rehabilitation Research (NIDRR), said insuring that research contributes to an improved quality of life for consumers is a priority. He said NIDRR seeks to improve the research it funds by increasing input from people with disabilities,

The presentations included research on risk factors for children's mental health and empowering families.

Terry Sullivan, Ph.D., acting executive director of the Premier's Council on Health Strategy in Ontario, said the government sought research data to help solve the problem of children with serious emotional disturbances. David Offord, M.D., research director of the Chedoke Child and Family Centre at McMaster University, led the Ontario Child Health Study, which sought to find risk factors. The study found a strong relationship between low family income and mental health problems with children.

Center Director Bob Friedman introduces a conference session with Center Advisory Board Chair Christina Young and David Offord, M.D. of McMaster University in Ontario, Canada.

Offord found that between the ages of 6 and 16, one in five children have a diagnosable emotional disturbance including conduct disorder, attention deficit disorder somatic disorders, and anxiety disorders. Of children between age 4 and 12, 43 percent of those with conduct disorders still had the disorder 4 years later.

Based on the research, Offord gave three possible public health approaches for intervention: a milestone approach providing children with services at certain ages; an approach targeted at high risk groups of children; and a community approach such as focusing on children who live in subsidized housing.

Offord's results were used by the provincial government to establish preventive programs for children at high risk. The children will be tracked for 25 years in order to evaluate the effectiveness of the services, Sullivan said.

Carl J. Dunst, Ph.D., director of the Family, Infant, & Preschool Program at the Western Carolina Center focused on family empowerment. Dunst said empowerment should focus on strengthening the competencies families already have through straight-forward and simple interventions.

Dunst presented a study comparing families who were given respite services only to families who were taught how to mobilize resources on behalf of their child. The resource mobilization group positively increased their sense of control and self-concept. The group that received only respite services did not increase their sense of control and their self- concept declined.

One study presented gave insight into children's point of view. Lucille Eber, Deputy Director of the Department of Special Education in LaGrange, Illinois, followed four children taken from a residential treatment center and placed in a regular junior high school. She found that friendship and socialization were the most important issues for the adolescents. One child became popular and played sports at the regular school but was regarded as having a bad attitude by the staff at the residential center where he was living. Eber found that children placed in a more normal environment behaved more normally and stayed within the bounds of what was acceptable at the school.

Other presentations included research issues on financing of mental health services. Richard Frank, assistant director of the Center on Organization and Financing of Care for the Severely Mentally Ill at The Johns Hopkins University said economic research should be conducted on topics such as the financial incentives contained in intergovernmental grants and contracts and on the efficiency of various types of governmental structures for mental health services.

Conference proceedings should be available by the end of the year. Proceedings from last year's conference, 3rd Annual Research Conference, A System of Care for Children's Mental Health: Building a Research Base, are now available. For more information on this year's conference or to order proceedings from last year, write Alissa Algarin at the Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL, 33612-3899.

National Public Hearings Held on Children's Mental Health

"Mental illnesses as they occur in children and adolescents are among the most important and vital underserved health problems." With that declaration, Dr. Lewis Judd, Director of the National Institute of Mental Health (NIMH) at the time, convened a one-day national public hearing on children and adolescents with mental disorders in Los Angeles, October 9, 1990.

The national hearing was the second in a series of hearings on "Mental Illness in America," co-sponsored by the National Advisory Mental Health Council (the advisory body to NIMH) and the National Mental Health Leadership Forum (a coalition of mental health organizations). The first hearing, on rural issues, was held in Marshall, Minnesota on April 12, 1990.

In opening the hearings, Dr. Judd indicated that mental disorders "occur far earlier in life than we ever thought before." He refered to the results of a recently released study by NIMH researchers (K. Burke, J. Burke, D. Regier, and D. Rae). The study found that obsessive-compulsive disorder often begins as early as 15-19 years of age; 15-19 years of age is one of the peak ages for onset of serious depression; the peak time of onset for phobias is between 5 and 9 years old; and the peak age for development of alcohol and drug abuse dependence is 15 to 19.

Actress Patty Duke described her personal experiences as a young adult with a major mental illness. This presentation was followed by a panel of six families describing the nature of their children's disorders, and their experiences in seeking assistance.

Actress Patty Duke shares her experiences with mental illness during a hearing in Los Angeles.

A series of concurrent hearings were held on topics such as risk factors for mental disorders, depression and suicide in children and adolescents, the impact of stigma, financing of services, advocacy, access to services, public-private sector coordination, service system issues, graduate education, and hospital issues. Altogether, almost 100 hearing witnesses made presentations to the hearing officers.

The service system panel specifically focused on recent developments in the states of California and Pennsylvania. The California panel described the success of an inter-agency children's demonstration project in Ventura County and presented a broader pictureof inadequate resources and severe cutbacks in areas such as Los Angeles.

The Pennsylvania panel focused on Philadelphia and also described the dilemma of the absence of adequate financing as the need for services was increasing. This panel indicated that through the efforts of the NIMH-funded Child and Adolescent Service System Program there has been significant progress in developing county-based, inter-agency efforts to improve services.

The testimony will be summarized, distributed to the U.S. Congress, and made available to the general public. For more information, contact the National Advisory Mental Health Council, NIMH, Room 17C-20, 5600 Fishers Lane, Rockville, MD, 20857, or call 301/443-3175.

RTI Report Finds CASSP States Made Progress

The first ten states to receive Child and Adolescent Service System Program (CASSP) grants generally achieved their goals of increasing the availability of less restrictive services, according to a report by the Research Triangle Institute (RTI) Center for Social Research and Policy Analysis.

The RTI report by William E. Schlenger, Rose M. Etheridge, David J. Hansen, and Doreen W. Fairbank, gave an overview of the activities of the original cohort of CASSP states.

In 1984, 10 states (Alabama, Alaska, Georgia, Hawaii, Kansas, Maine, Mississippi, New Jersey, Ohio, and Wisconsin) were given $150,000 each to support new initiatives in the service delivery system for children and adolescents with serious emotional disturbances. The goals of the project were to: improve and create continuums of care; improve the availability and access to services across child service systems; increase allocations of resources for child and adolescent mental health services increase the levels of collaboration; and develop and provide technical assistance.

In most of the states, services became available that had been previously unavailable and the new services tended to be less-restrictive, community-based services.

In all of the states, the size of the central office for child and adolescent programs in the departments of mental health increased, and the allocations of funds for programs and services increased.

Some of the other accomplishments of the states included: more types of community-based services became available; the capacity of existing services was increased; in some states, inpatient treatment funds were redirected to support community-based services; interagency coordination improved due to CASSP; and family participation improved.

For a copy of the RTI report, Final Report: The CASSP Initial Cohort Study, Volume I: Cross-Site Findings, contact William E. Schlenger or Rose M. Etheridge at the Research Triangle Institute, Research Triangle Park, P.O. Box 12194, NC, 27709-2194.

Cultural Competence Meeting Expands Knowledge

About 300 people from 44 states gathered in Boulder, Colorado, July 22 to 26, 1990 for training institutes designed to illustrate effective services for African American, Asian American, Hispanic American, and Native American children and families.

The training institutes were sponsored by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center. The CASSP Minority Initiative Resource Committee planned the institutes as part of an effort to develop "culturally competent systems of care for children of color who are severely emotionally disturbed."

The concept of a culturally competent system of care was described to the participants in a plenary session by Terry Cross of the Northwest Indian Child Welfare Institute. In his presentation, Cross expanded on the concept of a culturally competent system which was originally described in a monograph produced by the CASSP Minority Initiative Resource Committee, *Towards a Culturally Competent System of Care*. He illustrated with specific activities that would help promote such a system.

The keynote presentation for the training institutes was given by Dr. Wade Nobles of the Institute for the Advanced Study of Black Family Life and Culture in Oakland, California. His talk focused on the importance of culture in improving services.

Terry Cross, Northwest Indian Child Welfare Institute and Wade Nobles, Institute for the Advanced Study of Black Family Culture, at a training institute in Boulder, Colorado.

In addition to the presentations at plenary sessions, program descriptions were made by about a dozen organizations identified by the CASSP Minority Initiative Resource Committee as illustrating a high level of cultural competence.

According to Marva Benjamin, Director of the Minority Initiative for the CASSP Technical Assistance Center, "the Institute seemed to serve as a catalyst for future development in the field." In particular, she emphasized that two of the most important things that have come from the Institute were the creation of a minority parent caucus, and the increased attention to the concept of cultural competence from training programs within the general university community.

Additional information about the Institutes or the CASSP Minority Initiative is available from Marva Benjamin, CASSP Technical Assistance Center, Georgetown University Child Development Center, 2233 Wisconsin Avenue, NW, Washington, DC, 20007, 202/338-1831.

RWJ Grants Making Progress

The eight states chosen to receive four-year grants from the Robert Wood Johnson Foundation are improving services for children and youth with serious emotional disturbances, said Michael Beachler, Program Officer.

The eight states and their grants:

California	$1,488,378.00
Kentucky	1,491,266.00
North Carolina	1,468,611.00
Ohio	1,500,000.00
Oregon	1,369,192.00
Pennsylvania	1,480,706.00
Vermont	1,460,041.00
Wisconsin	1,500,000.00

"There is starting to be a real change in the way services are financed," Beachler said.

The eight states were chosen from 12 sites which were first given planning grants in July, 1989. Beachler said the factors which made the eight states stand out were their ability to demonstrate the establishment of a continuum of services and to work together on the state and community level as a team.

The program seeks to develop state-community partnerships that can make changes in financing, organization, and delivery of services. States are expected to create financing plans to maximize existing resources and secure additional funding. Communities will be expected to develop strong interagency agreements coordinating mental health services with medical care, child welfare, education, and juvenile justice.

Some of the states have already made significant progress towards their goals. Kentucky's state legislature has approved an additional $19 million for mental health and supportive services for children. Ohio's Cuyahoga County has appropriated an additional $500,000 per year in new mental health related funds for children. North Carolina has expanded its Medicaid and child welfare financing to cover approximately $21 million in new mental health and supportive services for children.

The program is directed by child psychiatrist Mary Jane England, M.D. For more information, contact her at the Washington Business Group on Health, Suite 800, 777 N. Capitol St. NE, Washington, DC, 20002, 202/408-9320.

Study Reports State Mental Health Dollar Expenditures by Age Group

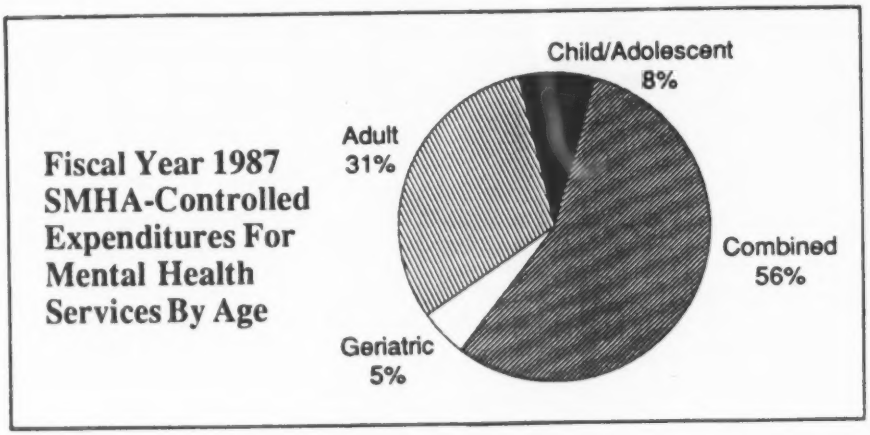
A recent report on expenditures of state mental health agencies in fiscal year 1987 shows that of the money that could be accounted for by the age of the client served, only 18% was spent on children. In contrast, 70% was spent on adults (age 18 through 65), and 12% was spent on geriatric clients (over the age of 65).

These findings come from a study conducted jointly by the National Association of State Mental Health Program Directors and the NASMHPD Research Institute, Inc.

The total mental health expenditure controlled by SMHAs for FY 1987 was slightly over $9.3 billion. Of this amount, approximately 80% of all SMHA revenues were from state government sources (mostly state general funds) and the remaining 15% were federal funds.

Only 44% of SMHA expenditures could be broken down by age group. Of this total, 8% was for children, 31% for adults, and 5% for geriatric clients. When these percentages are projected to total SMHA expenditures, it is estimated that 18% or $1.7 billion was spent on children.

Children and adolescents represented 27% of the total United States population in 1987. This indicates that children and adolescents were under-represented in expenditures relative to their percentage of the population, while both the adult and geriatric group were over-represented.



These figures may represent a slight underestimate of the actual percentage of all state mental health expenditures for children and adolescents, however, because other state and community agencies also provide funds for services for children with severe emotional disturbances.

SMHA expenditures were also broken down for the major SMHA programs. For example, 1987 expenditures for state mental hospital programs represented 63% of total SMHA-controlled expenditures while community-based programs averaged 32%. SMHA expenditures for state mental health hospital programs decreased 9% while community-based program expenditures increased 8.4% from 1981 to 1987 when compared in constant (1981) dollars.

For a copy of the report, contact NASMHPD at 1101 King Street, Suite 360, Alexandria, VA, 22314, 703/739-9333.

Illinois Begins Assistance Program for Families of Youth With SED

The state of Illinois has begun the first program that provides direct cash assistance to families with children with serious emotional disturbances, said Connie Sims, coordinator of the Family Assistance and Home-Based Support Services Program.

The program is modeled after similar programs in Michigan and Wisconsin that provide entitlements to families with children with developmental disabilities, Sims said. The pilot program in Illinois provides money directly to families so that they may purchase services within their communities, improve the quality of the services they receive, and reduce the rates of institutionalization.

A monthly payment of about $400, equal to the SSI payment in Illinois, will be provided to families who have children with serious emotional disturbances (SED) or have developmental disabilities (DD) and have a family income of less than $50,000. There are no restrictions on how the money may be spent nor will the state attempt to track how the money is spent. The program is limited to 280 families, 140 each from the SED and DD groups.

While the DD slots are full, the state is still trying to fill the SED slots. Sims said that most of the initial applications for SED were actually eligible for the DD group, such as families with children who are autistic.

Sims said the program will continue through the next fiscal year, beginning July 1, 1991, and the search will continue for families until all the SED slots are full. She said all families that are eligible will continue to be funded for as long as they are deemed eligible for the program.

The Illinois legislature has tried repeatedly in the past to begin an assistance program for families with children with developmental disabilities; however the funding was never approved because so many families would be eligible, Sims said. This program, with its limited number of applications, was approved to serve as a demonstration project and was funded for $6.5 million.

An evaluation of the children's portion of the program is being completed by Robert Goerge of the Chapin Hall Center for Children in Chicago. Goerge will be looking at the families' experience of the application and verification process and what services the families buy in relation to what is available.

"I hope this is going to make a difference in the quality of life for these families," Sims said. "We hope to reduce the rates of institutionalization."

Sims said the families who have applied for the assistance represent a cross-section of all types of people in Illinois, from middle-class families to those who are currently receiving supplemental income benefits.

"The families have had nothing but wonderful things to say about the program," Sims said.

For more information on the program, contact the Family Assistance and Home-Based Support Services Program, Room 405, Straton Office Bldg., Springfield, IL, 62765, 217/782-7393.

Decategorization Efforts in Iowa Foster Collaboration

A project to decategorize the funding for child welfare services in four counties in Iowa is intended to lead to improved services for families and greater collaboration between the agencies that serve families, according to Dr. Judy Meyers of the Iowa Department of Human Services.

The Iowa General Assembly in 1987 told the Department of Human Services to develop a decategorized child welfare financing system to consolidate the funding which was available through 30 different funding streams into one child welfare fund, according to Charles Bruner, director of the Child and Family Policy Center, in a monograph about the program .

"The biggest complaint was that the system was not terribly effective or efficient," said Susan Yelton, a consultant to the project. "There was duplication and differences in policy and procedures."

A highly fragmented service delivery system made service coordination and integration difficult, according to Meyers. Program-specific rules and funding constraints were hindering innovative service responses and clients were often having to fit into service categories rather than receive the service most appropriate for their needs.

The program was begun in Scott (Des Moines) and Polk (Davenport) counties in July, 1989 and was expanded to Dubuque and Pottawattamie counties in July, 1990. The initial two counties each developed a governance structure for the fund that required the consensus of the county department of human services, the county board of supervisors and the county juvenile court, wrote Bruner. The counties initiated more prevention and early intervention services by finding ways to serve existing child welfare clients more efficiently. Each county also developed a better client tracking system that was based on the family, restructured the roles of front line workers, and identified service gaps, Bruner wrote.

The results were resource and funding flexibility without increasing the current budgetary levels, services based on client need, rather than narrow categorical program criteria and increased interagency cooperation through planning, resulting in an improved service delivery system, according to Meyers.

In Scott County, several 9-to-11-year-olds in residential treatment were returned home with the development of a day treatment program and collaboration with the school system and special education funding, Bruner wrote.

One 7-year-old boy who had been in 16 different placements in the past 3-and-one-half years was going to be sent to a hospital in Texas, Yelton said. Instead, a private provider helped to design a program for him in his community that included one on one tutoring for the child, counseling and tutoring for his mother who could not read or write, helping the mother get to the facility and helping her to get housing.

"Traditionally they would not have been able to put together this type of plan," Yelton said. "It is a real family plan with help from people in the community. Now the counties have the capacity to give money to the workers so they can buy things for families. It empowers the workers to be much more effective."

Some of the other improvements made through the project, according to Meyers, include coordinated, interagency services intake; increased and enhanced in-home and aftercare services; enhanced, local residential treatment resources; increased local day treatment resources; and innovative individual programming to serve youth in the community as an alternative to out-of-state placement.

For more information on the project, contact the Iowa Department of Human Services, Hoover State Office Building, Des Moines, Iowa, 50319-0114, 515/281-3582.

Continued from page 2.

* * *

As this issue of Update indicates, there is another major federal reorganization taking place with regard to the National Institute of Mental Health. This reorganization will result in a split of the research and service efforts into separate agencies. To many of us who believe that the federal government has a major role to play both in supporting research and improving service delivery, and who further believe that these two efforts should operate in partnership with each other, this split is unfortunate. In particular, our Center has always emphasized the need for all kinds of research but especially for strong programs of service delivery and system of care research in order to provide an empirical basis for improving services. We have been gratified to see an increased recognition of the need for this type of research, and have been pleased as well to see considerable growth in the capacity of the field to conduct services research.

Within the federal mental health structure as it is about to be reconfigured, we must ask where system of care and service delivery research should be placed so that it can flourish and have its greatest impact. As a service system researcher, I clearly believe that there is a need for a focus on such research both in the scientifically oriented NIMH and the more service oriented Office of Mental Health Services. Any well-rounded program of health care research must have a strong services focus if it is to be of maximum benefit, and this is particularly the case in mental health where the services required are often multiple and come from a variety of agencies and funding streams. Similarly, any effort to support mental health services must be based on a research base and must include the capacity for ongoing services research and evaluation.

It is therefore hoped that services research will be included prominently in both organizations, and that steps will be taken to insure that there is close collaboration on services research issues between the two organizations.

* * *

From the inception of the Child and Adolescent Service Systems Program in 1984 until his retirement from federal service in April, 1991, Dr. Ira Lourie served as CASSP Director. It has been my personal good fortune, and the good fortune of our Center, to have an opportunity to work closely with Ira during these seven years.

Under Ira's leadership during this time period, the children's mental health field has undergone improvements that far exceed anything that I ever anticipated would result from a federal program operating on a limited budget. While many people made important contributions to the overall effort, in his own unique and caring way, Ira provided both the technical and spiritual leadership needed to advance the field. On behalf of our Center, I want to thank you for all you have done, Ira, and for the special style and grace that you bring to everything you do. Here's to many more personal and professional successes, and to our future activities together.

81

RESOURCES UPDATE

Research and Training Center for Children's Mental Health

The Research and Training Center for Children's Mental Health (RTCCMH) of the Florida Mental Health Institute is funded by the National Institute on Disability and Rehabilitation Research and the National Institute of Mental Health. The RTCCMH mission is to improve services for children with serious emotional disturbances and their families by increasing the knowledge base for such services. As part of its commitment to this mission, RTCCMH provides a variety of training, consultation, and dissemination activities.

An annotated bibliography describing materials prepared by RTCCMH staff is available upon request. Copies of material or further information can be obtained from Dr. Al Duchnowski, Director of Training, Consultation and Dissemination, RTCCMH, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899, phone 813/974-4500.

New products available from RTCCMH include:

-# 704 "Major Issues in Improving Mental Health and Substance Abuse Services for Adolescents," January 1991, R. Friedman, B. Burns, and L. Behar, White paper prepared for the American College of Mental Health Administration.

-# 560 Researchers and Advocates: Silent Partners in Improving the Children's Mental Health System, December 1989, Duchnowski, A.J., Kutash, K.B., & Friedman, R.M.

- EPA 136 ($35.10) 3rd Annual Conference Proceedings, A System of Care for Children's Mental Health: Building a Research Base (Feb. 12-14, 1990).

-EPA 132 ($35.00) 2nd Annual Conference Proceedings, Children's Mental Health Services & Policy: Building a Research Base (Feb. 27 to March 1, 1989).

-EPA 134 ($12.00) Conference Proceedings: Mental Health and Education: Partners in Serving Emotionally Disturbed Children (May 16-17, 1988).

-# 551 Examining The Research Base for Child Mental Health Services. Also available in The Journal of Mental Health Administration, 17 (1), Spring, 1990.

-# 702 Mental Health and Substance Abuse Services for Adolescents: Clinical and Service Systems Issues, December, 1990, Friedman, R.M.

This newsletter is prepared by RTCCMH staff to provide information about developments in services for children with serious emotional disturbances and their families. We invite you to reproduce the material and distribute the information in any way you wish for the purpose of increasing knowledge about the needs and services in children's mental health.

We ask you to acknowledge the source, and let us know how you used it.

Thanks!

UPDATE

Research and Training Center for Children's Mental Health
Florida Mental Health Institute
13301 Bruce B. Downs Blvd.
Tampa, Florida 33612-3899
813/974-4500

Forwarding and Address Correction Requested

Non-Profit Org
U.S. POSTAGE PAID
Tampa, Florida
Permit No. 257

BEST COPY AVAILABLE

Events, activities, programs, and facilities of the University of South Florida are available to all without regard to race, color, sex, religion, national origin, Vietnam or disabled veteran status, handicap, or age, as provided by law and in accordance with the University's respect for personal dignity.